HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 19, NO. 6, ABSTRACTS 777-931. JUNE 1979

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HOSPITAL ABSTRACTS

Vol. 19 June, 1979 No. 6

HOSPITALS IN GREAT BRITAIN

See also Abstract No. 835

777. CALNAN, J. **Another way to run the acute hospital service.** *World Medicine*, London, 1979, Jan. 27, vol. 141, no. 8, pp. 23-25, 27, 31, 32, 35.

Current problems in the hospital service in the United Kingdom are examined and five things that are wrong with the present system are listed: lack of imagination in attitudes and concepts; loss of morale; rising costs, some of which must be due to over-manning; militancy against doctors and patients on a scale never envisaged before; and failure to get organizational structures right. For success in an enterprise, objectives have to be set in seven key areas: marketing, innovation, human organization, financial resources, physical resources, productivity, and social responsibility. At least 10 needs in organization are required now: (i) an admissions ward; (ii) an out-patient service investigation unit; (iii) a day-case surgery unit; (iv) out-patient consultation units; (v) five-day wards; (vi) an intensive care unit for serious emergencies; (vii) full service wards for the desperately ill with the best nursing and medical facilities; (viii) pre-convalescent wards; (ix) special service units; and (x) greater delegation, authority, responsibility, and accountability within and between teams in charge of patient care. Lines on which such an organization would function are outlined.

HOSPITALS IN OTHER COUNTRIES

See also Abstract Nos. 814-816

778. JEAN, M. P. Évolution de l'image et du rôle de l'institution hospitalière française à travers les changements de la société depuis le 18ème siècle. **[Development of the image and role of French hospitals through the changes in society since the 18th century.]** *Revue Hospitalière de France*, Paris, 1979, Jan., vol. 43, no. 317, pp. 7-12.

In the 18th century in France, the hospital was a refuge for the needy where an almost penal regime was in operation. In the 19th century it became a hospital in the modern sense of the word in so far as it was there that free treatment was available from the best doctors of the day. 'Paying patients' were admitted from the 1930s onwards, but it was only in the 1950s that the middle classes began to frequent the public hospitals, having studiously avoided them until then, because of the rigidity of the regime, its dreariness, and its inhumanity. To-day people from all social classes are using the hospitals because only there are facilities available for advanced medicine and surgery, and also because an intensive programme of 'humanization' has made them more attractive. However, their image is still poor and they are constantly, if unfairly, under attack in the media.

779. BETHUME, E. and LECLERCQ, F. L'hôpital Civil de Tournai. **[Tournai Civil Hospital.]** *Hôpital Belge*, Bruxelles, 1978, Nov./Dec., vol. 21, no. 136, pp. 7-8.

A brief description is given of the services provided by the Civil Hospital at Tournai to which a new geriatric wing has recently been added. The hospital now has 466 beds. The wing devoted to acute patients is at right angles to the central block which houses all the technical services, and the new geriatric wing, again at right angles to the central block, has 192 beds.

780. KRICHEWSKY, M. Une alternative allemande: l'hôpital communautaire d'Herdecke 5804 Herdecke Beckweg 4. **[Herdecke Community Hospital 5804 Herdecke Beckweg 4, West Germany.]** *Revue Hospitalière de France*, Paris, 1979, Feb., vol. 43, no. 318, pp. 171-183.

The organization and work of this 484-bed private hospital in Southern Germany which is run by the followers of Rudolf Steiner (anthroposophists) is discussed. There is no chief medical officer or chief nursing officer: responsibility is shared and each doctor is responsible for about 16 patients; the doctor and nursing staff constitute a unit which is small enough for the quality of the doctor-nurse-patient relationship to be maintained. The atmosphere is informal and visitors are free to come and go at any time. In addition to the 330 beds devoted to medicine, surgery, gynaecology and obstetrics, the hospital has 28 beds for psychiatric patients and 126 for paediatrics and child psychiatry.

PLANNING, DESIGN AND CONSTRUCTION

781. HARDY, O. B. and LAMMERS, L. P. **Hospitals: the planning and design process.** Germantown, Md., Aspen Systems Corporation, 1977, [xi], 260pp. $29.75

This book describes the major activities inherent to the planning and design process, largely from a how-to-do-it viewpoint, and attempts to arrange the total process in realistic and appropriate sequences. There are 14 chapters which consider the planning process from the initial design and include: financial planning; role planning; physical and functional evaluations; space planning; master site planning; the preparation of documents; the construction phase; modernization; design efficiency; and the establishment of management control.

HOSPITAL DESIGN

See also Abstract No. 851

782. BOTZENHART, K. Stellenwert baulicher Massnahmen für die Krankenhaushygiene. **[The value of building measures for hospital hygiene.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 388-390.

This paper discusses the possible effects of structural measures on hospital hygiene and the control of hospital infections. The principal means of transmission of micro-organisms are briefly set out and the ways in which structural features can affect the spread of infection are illustrated in three areas: intensive care units; bed disinfection centres; and milk kitchens. In the case of intensive care units the problem is not so

much to prevent the spread of infection into or out of the unit but within the unit from patient to patient. Central milk kitchens mean that infants' food can be prepared more efficiently than on the wards but these advantages have to be weighed against possible increase in infection risks. Central units for the disinfection and storage of beds are tending to be replaced by decentralized units on each floor to lessen the risk of the spread of infection during transit of beds to the unit.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See Abstract Nos. 779, 780

DESIGN OF SPECIAL HOSPITALS OR UNITS

See Abstract Nos. 893, 900

WARDS AND PATIENTS' ROOMS

See Abstract No. 901

GUIDING AND SIGNPOSTING

783. SPRI. Vägvisning inom sjukhus och andra sjukvårdsanläggningar med termer för vägvisningsskyltar. **[Signposting in hospital.]** Utgåva 2, Okt. 1977. (Projekt 1005; Spri Råd 1.2) Stockholm, Spri, 1977, 37pp.

This second edition expands on the signposting terms and the guidelines for signposting established by Spri in 1972. The publication now includes some 900 terms relating not only to clinical departments, sections and other similar organizational units, but also to functions and rooms within the units in the medical care centre which are chiefly of importance for showing the way within the unit. Aspects covered include: choice of terms, principal viewpoints and practical application; sign erection—function, design and finance; other sources of information; and planning. Four appendices present information on the colour of signposts, a systematic and an alphabetical register, and a bibliography (pp. 36-37).

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

See Abstract No. 851

ARTIFICIAL LIGHTING

784. HAINAULT, M. L'éclairage en salle d'opération. **[Lighting in the operating theatre, part 1.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1979, Jan., no. 400, pp. 46-60.

This article contains the first six of 32 chapters of a survey of lighting for the operating theatre. These chapters are devoted to: (i) history, (ii) various optical

systems used (the Fresnel step lens, paraboloid and elliptical mirrors, and total reflection prisms); (iii) photometry; (iv) lighting systems: fixed lighting arches, the Holophane ceiling, mobile units such as the BBT Superscialytic lamp, and systems suspended from the theatre ceiling; (v) technical improvements; and (vi) closed-circuit television. Concise explanations and descriptions accompany the 40 clear and easily-understood diagrams.

COMMUNICATION SYSTEMS

785. GLAZER, E., MARSHALL, C. and CUNNINGHAM, N. **Remote pediatric consultation in the inner city: television or telephone?** *American Journal of Public Health*, Washington, D.C., 1978, Nov., vol. 68, no. 11, pp. 1133-1135.

A study was carried out in a primary care clinic for pre-school children in East Harlem to compare television and telephone links as a means of providing external physician consultation. During a period of eight months when both systems were available, 80.6 per cent of television consultations involved diagnosis as compared with 50.4 per cent of telephone ones. Only 19.4 per cent of the television consultations were purely therapeutic, compared with 49.6 per cent of those carried out by telephone. The study showed that nurse practitioners who staffed the clinic found the telephone acceptable for consultations concerned with therapeutics. However, in areas of diagnosis and patient management television was preferred because: (i) it was easier to reassure patients; (ii) the visual element was vital in orthopaedics and psychiatry; and (iii) television consultations could be video-taped and used in teaching or as part of the patient's medical record. Ideally, television and telephone should be introduced together for external consulting but, where this is not possible, television is generally preferred.

HEATING

786. KUSZPA, F. J. **Solar energy for hospital tower.** *Heating, Piping, Air-Conditioning*, Chicago, 1979, Jan., vol. 51, no. 1, pp. 75-80.

The 405-bed Danbury (Conn.) Hospital's solar energy project will include 19,000 square feet of flat plate solar collectors to assist in reheating domestic hot water and heat pump systems. The design philosophy and operation of the system are described. By using the technique of team designing the cost of the completed design has been kept to $840,641 which compares favourably with the cost of similar projects. Eight photographs and a diagram are included.

VENTILATION AND AIR CONDITIONING

See Abstract No. 786

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 791

787. SPRI. Underhäll av auläggningar och utrustning—arbetsordersystem och arbetsplanering. **[Building and equipment maintenance—work order systems and work planning.]** (Spri Råd 7.2) Stockholm, Spri, 1977, 50pp.

The increased investment in buildings and equipment within the health services has

resulted in increased operational and maintenance costs. The demand for maintenance has increased accordingly, and consequently it is essential that maintenance work should be carried out in a rational manner. Recommendations are provided for introducing the work order system with details on methods of providing information, carrying out the work and reporting.

PIPING INSTALLATIONS

788. BRITISH STANDARDS INSTITUTION. **Specification for medical gas pipeline systems: terminal units, hose assemblies and connections to medical equipment.** (BS 5682: 1978) London, B.S.I., 1978, [i], 15pp.

This British Standard specifies basic requirements for terminal units, hoses and connectors for the supply of medical gases, medical air and medical vacuum from hospital medical gas pipeline systems up to and including the pipeline inlet connections of medical equipment. The standard covers: materials; definitions; location of terminal units; mounting of terminal units; features of the terminal unit and probe; design of terminal units; probes; hose tail; inlet connection to medical equipment; hoses; hose assemblies; packaging; identification and colour coding. Three appendices consider: recommendations for inspection and maintenance; use of BS probe in existing terminal units; use of BS socket assemblies with termination blocks pre-dating this standard. Two tables and 11 figures are included.

EQUIPMENT, FITTINGS, FURNITURE

BEDS, COTS, ETC.

789. HOET, T. La distribution des fluides et des courants aux lits de l'unité de soins intensifs. **[Distribution of fluids and electric cables to intensive care beds.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1979, Jan., no. 400, pp. 42-45.

Two systems used in the intensive care unit at the Tivoli Hospital in La Louvière for holding electric cables and pipes for fluids and gases are described. The first is a stainless steel case supported by two metal columns and divided into two compartments, the rear one for the gas and fluid connections and the other for the electric sockets. The second device is a barred frame attached to the ceiling which is used for suspending drip leads and an adjustable lamp. Three photographs and a sketch show how the use of these systems releases more space around the patient's bed by confining all leads and equipment to the head of the bed.

EQUIPMENT GENERALLY

See also Abstract Nos. 789, 850, 857, 886

790. AMERICAN SOCIETY FOR HOSPITAL ENGINEERING. **A hospital recall and reporting system for medical devices.** Chicago, American Society for Hospital Engineering, 1978, vii, 20pp. $4.50

This publication was developed by the Clinical Engineering Steering Committee of

the American Society for Hospital Engineering in its effort to assist hospitals in the safe management of medical equipment. Two systems for hospitals are described: a system for recalling medical devices and a system for reporting problems with or defects in medical devices. The booklet defines the classes of recalls as classified by the Food and Drug Administration, describes the responsibilities of manufacturers and hospitals in recalling medical devices, and provides step-by-step procedures for establishing an in-house recall system and an in-house reporting system.

MEDICAL EQUIPMENT

See also Abstract No. 885-888

791. AMERICAN SOCIETY FOR HOSPITAL ENGINEERING. **Medical equipment management in hospitals.** Chicago, American Hospital Association, 1978, v, 522pp. $45.00

This book is divided into sections dealing with different hospital departments, including central supply, clinical laboratories, emergency room, inhalation/respiratory therapy, nuclear medicine, nursery, obstetrics, physical therapy, physiological monitoring, radiation therapy, surgery and X-ray. Within each section a table lists the items of equipment and this is followed by preventive maintenance procedure sheets for that equipment.

792. BLISS, M. and MURRAY, E. **The use of ripple beds.** *Nursing Times*, London, 1979, Feb. 15, vol. 75, no. 7, pp. 280-283.

Ripple beds, especially the large cell variety, prevent pressure sores by mechanically varying the supporting points of pressure beneath the patients' body. The bed is an air mattress laid on an ordinary mattress and operated by an electrically powered pump. Its action is described. Draw sheets and incontinence pads can be used with ripple mattresses, but bulky objects should be avoided. At present, a large celled ripple bed costs about £50 and replacement cells are supplied. Running costs are about one penny per day. However, often the more expensive and less practical water bed is used because nurses generally have very little training in the care and operation of alternative pressure beds. The condition of ripple beds in most wards is appalling and often there is no provision for maintenance and servicing. The standard model is not strong enough, but manufacturers would make improvements if asked to do so. Doctors and nurses must be aware of which patients need ripple beds and for how long. Beds with ripple mattresses must be very carefully made and the mattress itself checked regularly for faults.

793. TOMSIC, K. E. Sicherheit von elektromedizinischen Geräten. **[The safety of electrical medical apparatus.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Sept., vol. 19, no. 9, pp. 439-440, 445-446, 448, 450-454.

Wherever electricity is used there is a latent hazard and the greatest risk factor is that danger is hidden but is always present. This paper is concerned with the hazards involved in the use of electromedical equipment in the hospital. Protection is required at two levels; normal and special. Normal measures apply to wards, medical laboratories

and (in part) out-patient departments and examination rooms. Special measures are required in operating theatres, recovery rooms, intensive care units and dialysis units. A number of examples are given of faults which can occur in hospital electromedical equipment and of the harmful effects these can have both on patients and staff.

ELECTRONIC EQUIPMENT

See Abstract No. 855

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract Nos. 795, 908

RECRUITMENT AND MANPOWER

See also Abstract No. 796

794. SPRI. Personalrörlighet på vårdavdelningar. **[Staff mobility on hospital wards.]** (Project 3041; Spri Rapport 5/78) Stockholm, Spri, 1978, 56pp.

This study describes a survey method for measuring hospital staff mobility, its extent and causes. The method was first tested in a pilot study and has since been used on 16 hospital wards at hospitals in Stockholm, Gothenburg and Linköping. The method is recommended for use in other countries which have problems with high staff mobility and wish to analyze the reasons for such mobility as a basis for various counter measures. The study reveals that the main reason for the current high level of staff mobility is a failure to make sufficient allowance for an absenteeism trend which afflicts society as a whole.

CONDITIONS OF SERVICE

See Abstract No. 797

STAFF MANAGEMENT

See Abstract Nos. 801, 802, 810

STAFF TRAINING

See Abstract Nos. 803-808, 811, 836

STAFF WELFARE

See Abstract Nos. 854, 922

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 785, 882, 929

795. Le corps médical hospitalo-universitaire. **[Medical staff manpower in teaching hospitals in France.]** *Hôpital à Paris*, Paris, 1978, Nov./Dec., no. 48, pp. 507-513.

This is an analysis, with a short commentary, of the number of doctors, dentists, and pharmacists employed by the *Assistance Publique* over the period 1965 to 1977. The total number of hospital doctors rose from 1,240 in 1964 to 2,341 in 1977 and the total number of heads of departments rose by 41 per cent during that period. This was mainly because five new hospitals came into operation, some very large departments were divided, and biological laboratories and some clinical units became autonomous departments. The 1958 University Hospital Act reduced the number of part-time medical staff from 75 per cent of the total in 1964 to nine per cent by 1977. The number of second, third and fourth-year medical students rose gradually from 4,582 in 1967 to 6,124 in 1975 and then fell to 5,485 in 1977. Before 1965 the *Assistance Publique* employed no dentists, but five centres for teaching, treatment, and research in dentistry have been opened in the past 12 years, and there are now seven full-time professors of dentistry and 262 other part-time dental staff.

796. UNITED STATES. BUREAU OF HEALTH MANPOWER. DIVISION OF MEDICINE. MANPOWER SUPPLY AND UTILIZATION BRANCH. **Physician requirements forecasting: need-based versus demand-based methodologies.** (GMENAC Staff paper No. 3; DHEW Publication No. (HRA) 78-12) Hyattsville, Md., Bureau of Health Manpower, 1978, v, 28pp.

The aim of this paper is to help the Graduate Medical Education National Advisory Committee (GMENAC) to develop its choice of methodologies for forecasting physician manpower requirements from which a comparison between future supply and requirements can be made. From such a comparison it should be possible to consider the mix of residency training positions needed to produce a requirement—supply balance by target year. The report is in three sections: part one defines the problem; part two considers issues in measuring physician requirements; and part three considers issues in requirements forecasting common to all methods. A summary and short list of references (p. 28) are included.

797. BEAUMONT, B. and GRÜNEBERG, A. **The new consultant contract and women senior registrars.** *British Medical Journal*, London, 1979, Feb. 3, vol. i, pp. 359-360.

The percentage of women as consultants and senior registrars is likely to increase, but no provision to meet women's demands for limited session work has been made in the new consultant contract. The Medical Women's Federation has recently carried out a survey to discover whether there were any women senior registrars whose requirements were not met by the new contract. The average age of the respondents was 36, and

almost all had a caring commitment to children or other relatives. Half said they would be able to work eight clinic sessions as a consultant, the other half preferring or stipulating fewer than eight sessions, that is, less than the contract's commitment to 10 notional half days (NHDs). The following modifications are needed: (i) restrictive conditions should be removed from the clause permitting candidates to apply for posts involving fewer than 10 NHDs; and (ii) at least nine per cent of consultant posts in every specialty should be advertized as limited session, as at present 18 per cent of senior registrars are women.

798. YANDA, R. L. **Doctors as managers of health teams: a career guide for hospital-based physicians.** New York, AMACOM, 1977, viii, 271pp. £11.65

This book aims to give practical information and advice to American hospital-based doctors on management problems and how they can be solved. It includes chapters on the leadership, management and personnel functions, and also deals with topics such as political survival, finding the right post, remuneration and contracts. Two appendices give details of guidelines for contracts for a radiologist and a pathologist, and a short list of references is included.

NURSING STAFF

See also Abstract Nos. 794, 861, 869, 872-873, 894-895, 909, 925

799. SCHNELLER, E. S. **The physician's assistant: innovation in the medical division of labor.** Lexington, Mass., Lexington Books, 1978, xxviii, 160pp. £11.00

This book is a sociological analysis of the role of the physician's assistant in the United States. It is in four parts: part 1 is a study of the physician's assistant as a health manpower innovation; part 2 considers how to become a physician's assistant; part 3 outlines the role of the physician's assistant; and part 4 considers the problems and prospects of a competency-based occupation. The book draws its material mainly from statements made by physician's assistant students during their first year of training. The methods of obtaining the survey and interview data and of interpreting the results are outlined.

800. SCHWIRIAN, P. M. **Prediction of successful nursing performance.** Part I and Part II. (DHEW Publication No. (HRA) 77-27) Hyattsville, Md., Bureau of Health Manpower, Division of Nursing, 1977, viii, 226pp.

This study is currently published in two sections. Part I is a comprehensive review of the 1965-1975 literature relevant to academic and clinical selection and prediction criteria in nursing. Part II reports on the information provided by 151 schools of nursing on: (i) the adequacy and use of known criteria for predicting nursing performance; (ii) alternative criteria which nursing schools consider to be promising; (iii) operational definitions of successful and effective nursing performance; and (iv) identification of a cohort of 1975 graduating students considered to be highly effective performers. These students were followed up in 1976 to determine the relative effectiveness of school prediction criteria for later performance on the job. Part III of the study will consider the follow-up performance.

801. THOMPSON, D. J. C. **Staff development and performance review.** *Nursing Times*, London, 1979, March 1, vol. 75, no. 9, occasional papers, pp. 25-28.

The National Staff Committee for Nurses and Midwives issued its report on staff development and performance review in May 1977. Its proposals are generally considered an improvement on the previous scheme issued in 1970. The strengths of the new scheme lie in its emphasis on training, on forward-looking development action plans, and on more direct 'boss' involvement. It can be criticized on the grounds that it involves too much paperwork and that it still emphasizes appraisal rather than face-to-face counselling. The problems can, however, be overcome by modifying and adapting the proposed national scheme rather than by discarding it.

802. KING EDWARD'S HOSPITAL FUND FOR LONDON. **Nurses and leadership: a report of the third King's Fund Transatlantic Seminar of Nurses, 18-23 July 1976.** (Project Paper No. 19) London, King Edward's Hospital Fund for London, 1978, 153pp. £1.00

The papers contained in this report were presented at the third International Seminar of Nurses held at the King's Fund College in July 1976. The 11 papers consider various problems of leadership in the nursing profession and are in five sections: Section 1 considers the nature of leadership; section 2 defines the role and responsibility of nurses for leadership; section 3 considers the emergence of leaders; section 4 evaluates leadership; and section 5 considers the integration of theoretical presentation and its application to nursing situations.

803. FORD, J., REDMOND, I. and ROACH, F. **A pilot course on ward teaching methods.** *Nursing Times*, London, 1979, Feb. 1, vol. 75, no. 5, occasional papers, pp. 13-16.

The ward manager is regarded as an irreplaceable element in the training of nurses. This paper describes the development of a training programme designed to give experienced ward managers the principles of effective teaching in the clinical situation, and to demonstrate the most efficient methods of putting these principles into practice. The course was planned by members of the staff of Bromley Area School of Nursing and Bromley College of Technology who also shared the teaching sessions. The course involved one three-hour session a week for 11 weeks. Evaluation of the course suggested that it had achieved its objectives, but some changes are to be made in future courses.

804. GREAVES, F. **Teaching nurses in clinical settings.** *Nursing Mirror*, Sutton, 1979, Feb. 22, vol. 148, no. 8, supplement, pp. i, iii-iv, vii, x-xii, xiv-xv.

Trained nursing staff are expected to be involved with the teaching of students, and doing this in the clinical environment has a considerable practical advantage. Broad areas such as knowledge, procedure, total care, communications and the nursing process can be applied to specific clinical topics. Nursing staff must analyze the procedures and tasks carried out in their areas before attempting to teach. A framework for teaching should begin with a statement of objectives and the subject matter of each teaching session broken down into what the student must know, what she should know and what she could know. A prepared talk should be divided into introduction, development and conclusion, and discussion should be used to develop the central

theme. Clinical settings are ideal for practical instruction, although certain methods of demonstration may be unsuitable where patients are involved. Supervision, practice and telling the student how she is progressing, are all part of the teaching process. In addition, students should be directed to further study.

805. GREAVES, F. **Teaching nurses in clinical settings—2.** *Nursing Mirror*, Sutton, 1979, March 1, vol. 148, no. 9, supplement, pp. i, ii, iv, vi-viii, x-xii.

Patient centred teaching is the use of methods which are directly concerned with the care of the patient and are not concerned with subjects purely supportive to nursing. The methods considered here are the clinical nursing conference, clinical nursing rounds, ward report sessions, and individual procedures as learning events. The problem solving approach is also discussed and a format for creating problem orientated activities is presented. Some general aspects of the evaluation of learners are considered, with particular reference to the use of an attitude rating scale and ability check lists. Finally the use of teaching aids is outlined. Those mentioned include the use of the patient as an aid, nursing and technical equipment, blackboard and adaptations, overhead projectors, loop films, slides and cassette recorders.

806. ATKINSON, F. I. **Research summer schools: an evaluation. [1]** *Nursing Times*, London, 1979, Feb. 15, vol. 75, no. 7, occasional papers, pp. 17-20.

The Nursing Research Unit at the University of Edinburgh has organized a number of summer schools over the last six years to provide an opportunity for nurses to learn research methods and gain some experience in the assessment of research work. Since 1975 there have been three different levels of school: (i) research applied to senior management; (ii) research applied to nurse education; and (iii) an introduction to research. The objectives of each are outlined. The senior course was attended by 117 senior nurse managers between 1972 and 1977, but with a falling attendance. The educators' course has been attended by 63 teaching staff since 1975 and the introductory course has been attended consistently by 93 nurses from many areas of professional activity. All courses consist of lectures, discussions and group work. To arrive at an informal evaluation, each participant answered a questionnaire both before and after the course. Questions were aimed primarily at obtaining some idea of the relationship between the participants' objectives in attending the course and what they achieved by doing so.

807. ATKINSON, F. I. **Research summer schools: an evaluation. [2]** *Nursing Times*, London, 1979, Feb. 22, vol. 75, no. 8, occasional papers, pp. 21-24.

This paper discusses the results of a study carried out to evaluate the summer schools held by Edinburgh's Nursing Research Unit (see Abstract No. 806). Participants attending three levels of courses in nursing research were questioned about: (i) their existing research knowledge; (ii) their objectives in attending the course; (iii) their opinion of its length, usefulness, and content; (iv) their degree of achievement; and (v) their suggestions for course improvement. Of the nurse managers attending the senior course, about half had little research knowledge. The most commonly achieved objective was meeting others with similar research interests, but, although all found the course useful, few felt they knew how to implement research findings. About half

the nurse educators were attending the course for the first time and the most commonly achieved objective was learning how to stimulate a research interest in students. However, few found any help with the application of research to nurse education planning. Of the 93 attending the introductory course, 76 per cent found it useful, but this did not relate to individual efforts to initiate specific research projects. The findings of this study are imprecise, but do provide guidelines for course improvements.

808. WILLIAMSON, J. A. **Current perspectives in nursing education. Volume 2. The changing scene.** St. Louis, C. V. Mosby, 1978, xii, 125pp. £6.80

This collection of papers is intended to reflect certain aspects of the development of nursing in the United States, and particularly in nursing education. The 14 papers consider: patterns in nursing education; external constraints; politics, power and risk taking; academic nurse education; faculty development; the nurse preceptor; curriculum demands; graduate and doctoral education; nursing research; and nursing service and education.

809. HENDERSON, V. and NITE, G. **Principles and practice of nursing.** 6th edition. New York, Macmillan & London, Collier Macmillan, 1978, xiii, 2, 119pp. £17.25

The sixth edition of this book is intended as a guide to instructors and students of nursing. It is in five parts. Part I considers the role of nursing in health service; part II—the role of the nurse in health evaluation and planning patient care; part III—fundamentals of nursing care; part IV—therapeutic measures, procedures and techniques; part V—common problems—symptomatic nursing. Eleven appendices are included, together with illustrations, tables and selected references after each chapter.

810. PERRY, E. L. **Ward management and teaching.** 2nd edition. London, Baillière Tindall, 1978, xi, 336pp. £6.50

This book aims to be of assistance to nurses in charge of wards in all types of hospital. After an introduction which gives an overall picture of the ward sister's work, the book is divided into four parts. Part I 'the therapeutic team' examines the ways in which the ward sister works with other hospital staff to provide a service for the patient. Part II deals with the use of resources including staff, time, central supply services, accommodation and equipment. Part III covers the teaching role of the ward sisters and Part IV discusses the hospital and the community. References are included at the end of each chapter and the book also includes a list of useful addresses.

811. BIRCH, J. **The anxious learners.** *Nursing Mirror*, Sutton, 1979, Feb. 8, vol. 148, no. 6, pp. 17-22.

The author set out to measure anxiety levels in a sample of student and pupil nurses during the first two years of their hospital experience. The research design used included the Institute for Personality Testing and Ability Testing (IPAT) Anxiety Scale, and a simple questionnaire, which tested expressed anxiety in some 56 areas of clinical practice. The timetable was examined to discover how much emphasis was placed on psychological theory. The IPAT scale showed that anxiety levels were highest at the beginning and near the end of the course. Of 28 areas causing stress eight months through the course, 13 caused increased stress after two years, 14 diminished

and one remained the same. Ten of the 13 areas were behavioural, calling for an understanding of psychological needs. Of situations causing less stress, nine were administrative. However, even these caused more anxiety than any nursing procedure. The care of the dying and bereaved relatives received scant attention in curricula and controversial subjects were rarely discussed. Both students and pupils felt that not enough was taught about the behavioural aspects of care. Most curricula need re-structuring to include adequate psychological theory and reduce differing practices between classrooms and wards.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 777, 798, 880, 920, 924

812. KARGER, D. W. and VORA, J. A. **Integrated planning for health care organizations especially hospitals.** *Long Range Planning*, Oxford, 1979, Feb., vol. 12, pp. 91-96.

The concept of planning in relation to health care organizations is examined. Through an examination of the effects which proper planning can have upon industrial organizations, the authors analyze the possible impacts of planning procedures upon health care institutions. Their analysis leads to tentative conclusions as to the appropriate organizational structure which could support effective planning. Whilst the hypothesis is yet to be tested, the conclusions drawn from the initial analysis are worthy of further investigation.

813. GEORGOPOULOS, B. S. **Hospital organization research: review and source book.** Philadelphia & London, W. B. Saunders, 1975, xi, 487pp. £10.25

This is an account of a research project carried out to systematically review and evaluate research literature on hospital organization and intra-organizational relations. The book is in three sections. Part one consists of the introduction to the research and a discussion of the methodology; part two presents the quantitative findings, supplemented by descriptive material; and part three is a source book for the research literature reviewed in part two. The literature on topics of special interest to the practitioner in the hospital field is summarized in part three, while conceptual and theoretical aspects are considered in the analyses in part two. Two appendices and an annotated bibliography and name index are included (pp. 423-477).

814. HEUSGHEM, C. La programmation nationale hospitalière. **[The national hospital plan for Belgium.]** *Hôpital Belge*, Bruxelles, 1978, Nov./Dec., vol. 21, no. 136, pp. 53-58.

The objectives of the national hospital programme are to integrate the different types of care establishments and to ensure that all the health facilities in a region cover all the needs of the region; to adjust the number of beds to the actual needs of the population; to carry out modernization and conversion of out-of-date facilities, and to have an interdependent system based on the local hospital (90-235 beds, serving a population of roughly 50,000); the sector hospital (300-560 beds, population of 200,000), and the supra-regional hospital (870-1,000 beds, a hinterland of roughly one million inhabitants). It is also intended that psychiatric services will gradually be converted into hospital

departments, that extra-mural institutions will be developed for psychiatric and mentally handicapped patients, and that highly specialized facilities such as those for cardio-radiology will be available only in the supra-regional hospitals.

815. Soós, L. Munkaszervezés az integrált egészségügyi intézményekben, 3. **[Work organization in the integrated health care facilities, 3.]** *Egészségügyi gazdasági szemle*, Budapest, 1978, Sept., vol. 16, no. 3, pp. 302-319.

The third part of this study considers the methodology for co-ordinating ambulatory care demands together with the number of physicians and qualified health staff required; the methods for calculating the capacity of staff in the centralized diagnostic and therapeutic departments; and the methods for co-ordinating the management of household services. Basic problems of system organization are outlined, and the possible trends of the organization's development with regard to centralization are discussed.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 786, 819, 830, 874, 888

816. Turján, S. A költségek mérésének néhány feltétele az egészségügyi területén. **[Some conditions of the analysis of costs in public health.]** *Egészségügyi gazdasági szemle*, Budapest, 1978, Sept., vol. 16, no. 3, pp. 356-363.

The author believes that a deeper insight into the cost structure is required in order to improve the economy of hospital facilities in Hungary. It is suggested that the expenditures and the costs should be separated more distinctively. The registration and analysis of costs by the main fields of activity—household costs; diagnostic costs; and in-patient care costs is recommended. The checking of demands for the purchase of instruments should be carried out on to ensure economy.

817. Novak, D. G. **Texas voluntary effort—Texas hospital plan.** *Texas Hospital*, Austin, 1979, Feb., vol. 34, no. 9, pp. 15-19.

In November 1977 the United States health care industry was challenged to propose and implement a voluntary cost containment programme. The answer to this challenge in Texas included: (i) the establishment of the Texas Voluntary Cost Containment Committee, whose functions include policy formulation, review of co-operative cost containment plans of participating organizations, and monitoring of the overall plan, the Texas Voluntary Effort (TVE); (ii) the TVE plan itself; (iii) the Texas Voluntary Cost Containment Review Committee, which is charged with the special consideration of matters affecting the status of voluntary cost containment efforts; (iv) translation of each hospital's proposed budget for income and expenditure into that hospital's numerical goals; and (v) an appellate process by which hospitals may seek to change the goals allocated to them.

818. Warren, R. W. **Hospitals are saving more than lives—the Texas voluntary effort.** *Texas Hospital*, Austin, 1979, Feb., vol. 34, no. 9, pp. 11-14.

At the request of the Texas Voluntary Cost Containment Review Committee, the Texas Society of Hospital Purchasing Managers undertook a project designed to

collect data concerning the price range of certain commonly used medical supply items. From information submitted by 172 hospitals, the low, average and high prices paid by larger and smaller hospitals, both in and not in, purchasing groups, are presented for: 4×4 dressings, 16-ply, non-sterile; pre-jelled disposable electrodes; 3.00 cc. syringe/needle combinations; dextrose 5.00 per cent and water; sutures; sterile surgeons' gloves; Foley trays with catheter; and medical X-ray film 14×17. There are substantial differences between prices paid by larger and smaller hospitals and between prices paid by hospitals (in both size categories) participating in group purchasing programmes and those that do not. The information provides a firm foundation for monitoring price increases in certain materials and supplies.

RUNNING COSTS

819. PERSIN, M. N. **MIRC: Management Improvement to Reduce [Hospital] Costs: project summary and evaluation.** Battle Creek, Mich., W. K. Kellogg Foundation, 1978, 32pp.

This summary report considers hospital cost containment and the substantial commitment that must be made in order to achieve it. The Management Improvement to Reduce (Hospital) Costs project (MIRC) provides an example of the specific and related application of the Greater Detroit Area Hospital Council's commitment to the development and operation of a cost-effective health system in the seven counties of south-eastern Michigan through the application of advanced management technologies. Features considered include; description of the project; array of technologies; factors critical to the success of the scheme; admissions scheduling and control system; personnel staffing and scheduling; co-ordination of the budgeting methods; and development of a computerized budget system. The major conclusions of the MIRC project during its demonstration period are outlined showing the cost savings that can be made.

820. ZUBKOFF, M., RASKIN, I. E. and HANFT, R. S. **Hospital cost containment: selected notes for future policy.** New York, Prodist, for Milbank Memorial Fund, 1978, xi, 656pp. £22.90

The 19 papers consider components of cost containment strategies as they affect policy and decision making. There are five sections: overview of perspectives; decision making at the institutional level; federal state and local experiences; methodological issues in cost-containment procedures; and future outlooks. References are included after each chapter.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 898, 907, 926

821. HRADSKY, J. Krankenbettreservierung in den Wiener städtischen Krankenanstalten. **[Bed allocation in the Vienna municipal hospitals.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1978, Nov., vol. 19, no. 11, pp. 595-598.

In August 1978 a computer-based bed bureau service was introduced in Vienna and the first hospital (the Franz Joseph Hospital) was linked to it. Eventually all the 17

municipal hospitals (11,000 beds) will be included in the scheme which will have a total of 27 terminals connecting with the City's Council's mini-computer. The procedures whereby every patient needing a bed will be able to obtain the one best suited to him are described. The system is also linked with the city's first aid and ambulance services. In the case of a catastrophe the patient load will be able to be distributed on a much wider basis than has so far been possible.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 821, 825-826, 833, 883-884, 887-888, 913

822. Computertechnik und elektronische Datenverarbeitung in Dienste der Krankenversorgung. **[Computer technology and electronic data processing in the care of the sick.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, Nov., vol. 31, no. 11, pp. 572-587.

This is a series of four papers on computer techniques and electronic data processing presented at a course for nurses held in Berlin in May 1978. The titles of the papers are as follows: electronic data processing and patient admissions and the administration of patient data; data processing in day-to-day ward routine; laboratory data processing; and confidentiality and data protection.

823. COVVEY, H. D. and MCALISTER, N. H. **Computer-assisted medicine: skeleton, monster or servant?** *Canadian Medical Association Journal*, Ottawa, 1979, Jan. 20, vol. 120, no. 2, pp. 189, 192, 198-202, 227.

Previous papers have examined various devices separately. However, these individual pieces of hardware have to be assembled to form a computer system. If properly assembled, computer hardware provides a sturdy 'skeleton' and the addition of appropriate programming will transform it into a useful servant. This paper gives advice on: writing a specification for hardware; deciding whether to buy, lease or rent; and choosing a supplier.

MEDICAL RECORDS

824. DEMLO, L. K., CAMPBELL, P. M. and BROWN, S. S. **Reliability of information abstracted from patients' medical records.** *Medical Care*, Philadelphia, 1978, Dec., vol. 16, no. 12, pp. 995-1005.

Two recent studies by the Institute of Medicine, National Academy of Sciences, assessed the reliability of selected hospital discharge data items. The studies were national in scope and involved an independent examination of the medical record and a thorough review of the whole medical record. Information on hospital admission and discharge dates and sex was highly reliable, but serious questions were raised about the adequacy of information on diagnoses and procedures. A series of recommendations are offered to guide the use and improvement of abstracted medical record information.

825. UNITED STATES. OFFICE OF TECHNOLOGY ASSESSMENT. **Policy implications of medical information systems.** Washington, D.C., Office of Technology Assessment, 1977, x, 79pp.

This report is an assessment of the policy implications of computer-based medical

information systems. The Senate Committee on Human Resources asked the Office of Technology Assessment to examine: (i) the benefits and limitations of medical information systems; (ii) the factors influencing their adoption; and (iii) policy alternatives for the Federal Government with regard to such systems. The report begins with a summary of the findings and conclusions and the alternative policies that could be followed. Chapter two provides an outline for the assessment. Chapter three considers three different kinds of medical information systems. Chapter four discusses the implications of these systems on such areas of concern as quality of medical care, clinical decision-making, malpractice litigation, and confidentiality of data about patients. Chapter five considers the factors that influence the diffusion and use of information systems in the medical field. Chapter six considers a range of policy alternatives for maximizing the benefits of information systems. A bibliography (pp. 77-79) is included.

826. BARNETT, G. O. and others. **Quality assurance through automated monitoring and concurrent feedback using a computer-based medical information system.** *Medical Care*, Philadelphia, 1978, Nov., vol. 16, no. 11, pp. 962-970.

This paper describes the use of a computer-based medical information system (COSTAR) in a quality assurance scheme for the Harvard Community Health Plan. Data collection is an integrated part of the patient care recording activity and provides a monitoring system which is current rather than retrospective. This system enables deviations from quality care to be noticed very quickly and provides the appropriate feedback. The effectiveness of the system has been demonstrated in improving the consistency of the treatment of certain throat cultures. The system has been accepted by the medical staff and, because data are collected to make up an automated patient record, the monitoring and feedback involves only a small extra cost.

HOSPITAL STATISTICS

See Abstract No. 830

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract No. 923, 927

827. GRAY, T. C. and SHELLEY, F. C. **A medico-legal view.** *British Journal of Anaesthesia*, London, 1978, July, vol. 50, no. 7, pp. 721-728.

The legal relationship between doctor and patient is examined. The bulk of legal problems fall within the tort of negligence, which is the concern of most of this paper. The topics discussed are: the parties in legal proceedings; the duty of care; consent to treatment; preparation for induction of anaesthesia; and records.

828. MADLUNG, W. Aufklärung und Einverständniserklärung des Patienten. **[Informing the patient and obtaining his consent.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, Dec., vol. 31, no. 12, pp. 659-661.

Patients today, thanks to the mass media, are better informed on medical matters and on their rights; as a result claims for damages for alleged mistreatment are

increasing. The head of the legal department of the Hamburg Health Authority emphasizes the need for patients to be fully informed on the reasons for a proposed course of treatment or surgical operation, its nature, and the possible consequences if it is, or is not, carried out. The patient can then decide whether to give his consent or not. Hamburg is shortly to introduce a form (reproduced in the paper) on which the patient declares that the proposed operation or treatment has been explained to him, that he has given a full account of his medical history and that he consents to the treatment proposed as well as any additions or changes found necessary. The legal aspects of consent to treatment in the case of minors and those for any reason unable to speak for themselves are outlined. The patient's right to know is stressed although it is important for him to be told in a manner suited to his particular circumstances.

829. FARNDALE, W. A. J. **Law on hospital consent forms.** (Studies on Health Service Management Law and Practice Volume 8) Beckenham, Ravenswood, 1979, 95pp. £10.00

This study enlarges on the legal aspects of hospital consent forms and goes into some detail on court cases which form important precedents. The practical aspects of the nurse's role are considered together with some legal, moral and ethical aspects. The position of some special categories of patients is also considered. There is also a chapter on the law and practice on kidney donor forms, transplants and hospital post-mortems.

FINANCE AND ACCOUNTING

830. Les statistiques de comptes pour l'exercice 1975 des établissements d'hospitalisation publics. **[Financial statistics for 1975 for public hospital organizations in France.]** *Revue Hospitalière de France*, Paris, 1979, Jan., vol. 43, no. 317, pp. 13-77.

Financial statistics for 1975 for public hospitals in France are presented in a series of 46 tables, two graphs, three block graphs, and one diagram. They cover the financial operations (expenditure and receipts in 1975, and changes in the period 1971-1975), balance sheets, activities of the public hospitals in 1975 in economic terms, operations by region in 1975, and a study of analytical accounting during the 1975 financial year. Total expenditure in 1975 was 38,176 million francs—an increase of 27.8 per cent over the preceding year, and total receipts were 39,003 millions—an increase of 30.7 per cent over 1974.

COSTS

See also Abstract Nos. 817-818, 874-875, 888

831. BÜSCHER, H.-K. Entwicklung und Grenzen der Medizin im Krankenhaus. **[The development and boundaries of hospital medicine.]** *Krankenhaus umschau*, Kulmbach, 1978, Nov., vol. 47, no. 11, pp. 807-810.

Increases in medical costs, with special reference to hospitals, have deeper causes than purely economic ones. They depend on the understanding and assessment of illness on the one hand and on the explosive development of research and technology on the other. They are also related to extension of medical specialisms and the training of medical students. Restrictive budgeting policy can only play the role of an emergency brake, to the detriment of services.

832. MURPHY, H. M., editor. **Cost containment and quality control: report of a summer school.** (Australian Studies in Health Service Administration No. 34) Kensington, University of New South Wales, School of Health Administration, 1978, [v], 157pp.

This report of the summer school held on cost containment and quality control is concerned with problems directly related to containing and controlling hospital costs, while maintaining quality of care. The 18 papers consider policy options and mechanisms for containing costs, controlling the supply of services using financial incentives and administrative controls operating through the providers of health care services. A summary of the topics discussed by each syndicate and the conclusions they reached is included, together with a list of speakers and participants and the complete programme.

FINANCE

See Abstract No. 820

SUPPLIES AND STORES

SUPPLIES

See also Abstract Nos. 818, 893

833. MÜCKE, W. MARK-ein weiterer Schritt zur Automation im Krankenhaus. **[MARK, another step towards automation in the hospital.]** *Krankenhaus umschau*, Kulmbach, 1978, Nov., vol. 47, no. 11, pp. 811-813.

MARK is an acronym for 'Materialwirtschaft im Krankenhäusen' (materials management in hospitals) and is an electronic data processing system which maintains records of supplies and stores in general with a special section dealing with pharmacy records. It is described in detail in this paper under the following heads: preliminary work; collection of data and current movements; inventory; integration with other electronic data processing systems; the pharmacy section; and list evaluation. Proposals are put forward for possible extensions of MARK.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

834. SPRI. Prandium: system för näringsklassificering och näringsredovisning. Del 1. **[Prandium—system for nutrient classification and specification. Part 1.]** (Spri Råd 6.14) Stockholm, Spri, 1977, 24pp.

This Spri Recommendation (Part 1) contains a report on the *Prandium-System for*

nutrient classification and specification. The Recommendation describes the development work carried out on Prandium including a new system for nutrient classification, a method for calculating energy supplied by nutrients and a changeover from calories to joules. The Prandium system allows rational planning of meals irrespective of standards of nutrient supply or choice of food products. It is also an administrative tool which permits greater precision in the specification of nutrients in documents used for production planning and budgeting.

835. SUTTON, A. **Hotel for the sick avoids food budget worries.** *Caterer and Hotelkeeper*, London, 1979, Feb. 15, vol. 170, no. 3,050, pp. 49, 51, 53.

The 85-bed St. Anthony's Hospital, North Cheam, Surrey, is a private hospital run by an order of nuns. About 300 meals a day are provided for the patients, staff and visitors. Patients choose their meals from the menus on the evening before, and if there is nothing on the menu they like they can ask for something different. The meals are prepared in a small conventional kitchen and taken in heated trolleys to small ward wing galleys where they are partly plated before each patient is served individually. Staff and visitors eat in a self-service restaurant. The caterer is not compelled to work to a daily budget, but submits an annual estimate for food based on the costs of the previous year; he then has to account for his spending. Menus are changed every three months. A typical menu is reproduced. The kitchen is staffed by a head chef, sous chef, two assistants and two trainees.

836. NATIONAL STAFF COMMITTEE FOR ACCOMMODATION, CATERING AND OTHER SUPPORT SERVICES. **Report on a review of the national training schemes in catering and domestic services management.** London, D.H.S.S., 1979, 19pp.

The aims of the Working Group set up to review the national training schemes in catering and domestic services management, were to carry out a review of the schemes and to relate their findings to other groups of in-service staff and also direct entrants to NHS posts who have technical or managerial training needs. The method of work is outlined and the results of consultation with trainees and trainers discussed. Recommendations for interim changes to the 1977 schemes and future long-term changes are outlined. The Working Group recommend that the current four training schemes should be replaced by two and that each scheme should be devised to accommodate trainees of differing backgrounds and qualifications.

837. FAURE, P. and BOURRINET, P. Hygiène des plats cuisinés à l'avance. **[Hygiene of pre-cooked food.]** *Hôpital à Paris*, Paris, 1978, Nov./Dec., no. 48, pp. 531-537.

The reasons underlying the need for strict hygiene in regard to the preservation, transport, storage, and re-heating of pre-cooked dishes are explained with particular reference to the hospital environment, and the microbiological standards laid down by the 1974 Ministerial Order are presented. The advantages of using cold chain and hot chain pre-cooked food are discussed and the need to instruct kitchen staff in the rules of elementary hygiene is emphasized.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

838. NAGATA, M. K. **Hospital laundries, past, present and future.** *Administration hospitalière et sociale*, Montreal, 1978, Sept./Oct., vol. 24, no. 5, pp. 37-39.

The deficiencies of many hospital laundries are outlined and ways in which they can be improved, avoiding built-in obsolescence, are suggested. For metropolitan areas or regions where two or more hospitals are located within a 50-mile radius, one or more of the following approaches are considered: (i) increase laundry work schedule with additional work shifts and longer working week; (ii) expansion of laundry facilities and space at one hospital to accommodate two or more hospitals; (iii) use of commercial laundries; (iv) construction of a modern central laundry which is physically and administratively separate. The advantages and disadvantages of the first three approaches are discussed briefly. More attention is given to the central laundry, which is the course usually selected by hospitals, hospital districts and government.

HOSPITAL LINEN AND TEXTILES

See also Abstract No. 792

839. STAPLETON, M. **An evaluation of the Pneumatress.** *Nursing Times*, London, 1979, Feb. 1, vol. 75, no. 5, pp. 198-201.

The Pneumatress (illustrated) consists of two durable inflatable air cells 1.829 m long and shaped to operate with maximum efficiency at three pressure areas prone to bedsores. The air cells are positioned side by side beneath the conventional mattress. Each cell inflates independently over a 15 minute period, causing a gentle rocking motion which relieves stress points and encourages the motion of body fluids. The cells are inflated by a small electric pump which is designed to operate silently. The effectiveness of the mattress was evaluated on a three-ward, 62-bed orthopaedic unit. Patients and staff found the apparatus easy to use. Only one patient commented on the noise of the motors, but staff thought it noisy in contradiction to maker's claims. On the evidence provided by the study, it would appear that Pneumatress does not protect patients' beds, but it does offer help in preventing sacral sores, which make up 27 per cent of all pressure sores in the health district in which the study was carried out.

HYGIENE IN THE HOSPITAL

See also Abstract Nos. 782, 837

840. STEUER, W. Personelle Probleme der Krankenhaushygiene. **[Staffing problems in hospital hygiene.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 386-387.

In West Germany the Federal Health Office has issued guidelines on hospital hygiene and the prevention of hospital infection which include the following recom-

mendations on staffing. Hospitals with over 800 beds should have a full time hygienist who should be medically qualified and have had specialist training. Other hospitals should have one or more specialist doctors who devote part of their time to hygiene matters. There should also be a specially trained hygiene nurse for every 300 beds. A hygiene committee should be appointed with the following membership: the medical director; the administrator; the hospital hygienist; the chief nursing officer; the hygiene nurse; the director of technical services and the disinfection officer. The duties of the officers concerned are briefly described. There are problems with certain of these posts because there are not enough doctors and nurses with the necessary training and experience. However, there are moves to remedy this deficiency.

HOSPITAL INFECTIONS

See also Abstract Nos. 913, 916-917

841. AYLIFFE, G. A. J., LILLY, H. A. and LOWBURY, E. J. L. **Decline of the hospital staphylococcus? Incidence of multiresistant *Staph. aureus* in three Birmingham hospitals.** *Lancet*, London, 1979, March 10, vol. i, pp. 538-541.

The prevalence of antibiotic-resistant strains of *Staphylococcus aureus* was studied in a large general hospital, a burns unit in an accident hospital and a skin hospital in Birmingham. In the general hospital periodic surveys showed a progressive decline in the number of patients with strains of *S. aureus* in their noses which were resistant to tetracycline, erythromycin and kanamycin. This change was associated with a reduction in the use of tetracycline and an overall reduction in the use of antibiotics. There was no similar decline in the resistance to antibiotics in the skin hospital. In the burns unit, levels of staphylococcal strains resistant to antibiotics varied between September 1977 and December 1978, and were to some extent related both to the amount and type of antibiotics used and to the number of patients in the unit.

842. SCHNEIDER, H. Erfahrungen in der Hospitalismusbekämpfung. **[Experiences in the control of hospital infections.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, Dec., vol. 40, no. 12, pp. 835-837.

In Western Germany hospital hygiene is assessed on the basis of the provisions of German Standard DIN 1946, Part 4. The 13 military hospitals are inspected twice a year by the Institute for Defence Medicine and Hygiene. This inspection covers: (i) infrastructure and buildings; (ii) inspection of ventilation and air-conditioning plants; and (iii) inspection of rooms, staff, equipment and clothing in clean areas in relation to germ counts, presence of pathogenic bacteria, and presence of carriers. The report is discussed with the hospital staff and advice given on any outstanding problems. The hygiene specialist on the staff of each hospital is an important link between outside experts and the hospital staff. Details are given of procedures for dealing with contaminated equipment and materials.

843. BRIDGES, K. and others. **Gentamicin—and silver-resistant pseudomonas in a burns unit.** *British Medical Journal*, London, 1979, Feb. 17, vol. i, pp. 446-449.

Between June 1977 and September 1978 gentamicin-resistant strains of *Pseudomonas*

aeruginosa became very common in the Burns Unit at the Birmingham Accident Hospital, 90 per cent being resistant at the height of the outbreak. Some strains were also resistant to silver nitrate, but unlike the gentamicin resistance, the silver resistance was unstable. All the gentamicin-resistant strains of *Ps. aeruginosa* were of the same serotype. Although the gentamicin resistance could be transferred from resistant strains to one sensitive strain of *Ps. aeruginosa*, there was no evidence of such transfer of resistance between strains of pseudomonas in the patients' burns. The tests carried out are described in detail. The outbreak was not reduced by stopping treatment of burns with gentamicin and related substances, but only by segregating all patients with *Ps. aeruginosa* in one of two wards of the unit and admitting new patients only to the other ward.

844. PARKER, M. T. **Hospital-acquired infections: guidelines to laboratory methods.** (European Series No. 4) Copenhagen, World Health Organization Regional Office for Europe, 1978, [v], 63pp. Sw.fr.8

This publication discusses the use of various procedures for preventing hospital acquired infection, indicates when and by whom they should be applied and how the work of the laboratory should be integrated with the rest of the hospital's infection control activities. The six chapters consider: the nature of the problems; microbial causes, sources and routes of infection; organization for the control of infections; surveillance of infections; laboratory methods; investigation and control of outbreaks of infection; the infection control process; and education. Two annexes are included together with a selected bibliography (pp. 53-60).

845. PELINKA, H. Krankenhaushygiene in der Unfallchirurgie. **[Hospital hygiene in accident surgery.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1978, Dec., vol. 40, no. 12, pp. 832-834.

Risks of hospital infections are particularly great in accident surgery because of multiple injuries and the exposure of wound surfaces. This paper discusses control factors such as central recording of all cases of hospital infections, strict separation of septic and aseptic cases, and proper instructions as to the need for hospital hygiene measures. Another factor of great importance is close collaboration between medical staff and the hospital hygiene officer. The use of antibiotics is only of secondary importance in the prevention of hospital infections.

846. SPRATT, H. C. and others. **Nosocomial infantile gastroenteritis associated with minirotavirus and calicivirus.** *Journal of Pediatrics*, St. Louis, 1978, Dec., vol. 93, no. 6, pp. 922-926.

A study was made of an outbreak of acute gastroenteritis on the general infant ward of the Montreal Children's Hospital late in 1976. Diarrhoea occurred in 41 of 165 infants (25 per cent), of which 26 cases were probably hospital-acquired. Two infants were affected twice, and one three times. A putative pathogen was found in 31 of the 45 episodes and virus-like particles, belonging to one or more of six morphologic classes, were present in 28 patients. There was no set aetiological pattern for the whole ward, but minirotavirus and calicivirus or both were associated with diarrhoea in 20 infants, with vomiting in 15, and were the chief cause of the spread of diarrhoea by

room contact. This study supports other evidence that minirotavirus and calicivirus are a major cause of both diarrhoea and vomiting among infants in hospital.

SOURCES OF INFECTION

See also Abstract No. 921

847. SANDER, J. and MÄDLER, U. Durchseuchung von Patienten eines Krankenhauses mit chemotherapieresistenten Stämmen von Klebsiella pneumoniae. **[Hospital infection with strains of *Klebsiella pneumoniae* resistant to chemotherapy.]** *Deutsche Medizinische Wochenschrift*, Stuttgart, 1978, Oct. 13, vol. 103, no. 41, pp. 1593-1597.

In a 500-bed general hospital about 20 per cent of patients examined in surgical and medical wards were found to be carriers of *Klebsiella pneumoniae*. The organism was transmitted via the hands of staff and patients as well as by floors, furniture and washbasins. The use of broad spectrum antibiotics, especially ampicillin and cefalotin, is thought to be the main cause for the high incidence of Klebsiella: about 90 per cent of carriers had previously been given antibiotics.

848. FISHER, B. and others. **Outbreak of *mycoplasma pneumoniae* infection among hospital personnel.** *American Journal of the Medical Sciences*, Thorofare, N.J., 1978, Sept./Oct., vol. 276, no. 2, pp. 205-209.

An outbreak of respiratory illness due to *mycoplasma pneumoniae* occurred among employees of the Memorial Sloan-Kettering Cancer Center, New York in the later six months of 1975. The disease ranged from severe upper respiratory infection to pneumonia involving one or more lobes. No unusual increase in the incidence of respiratory illness occurred in the surrounding community at the time of the outbreak. It was not possible to identify any particular area of the hospital frequented by enough of the staff involved to explain the spread of the infection. The outbreak did not affect the patients and was the first of its kind to occur among hospital staff.

PREVENTION AND CONTROL

See also Abstract Nos. 841-844, 918

849. PLUECKHAHN, V. D. and others. **Hexachlorophene preparations in infant antiseptic skin care: benefits, risks, and the future.** *Medical Journal of Australia*, Glebe, 1978, Dec. 2, vol. 2, no. 12, pp. 555-556, 558-560.

The use of hexachlorophene preparations in emulsion and powder form is assessed at both the experimental and review level and is discussed in relation to efficacy, toxicity and strength of preparation, and its suitability against staphylococcal skin disease in newborn infants and mothers in maternity hospitals. Blood hexachlorophene concentrations during routine infant skin care with 0.75 per cent and 3.00 per cent hexachlorophene emulsions, and 0.33 per cent and 0.50 per cent hexachlorophene powders are given. The benefits and risks of using such hexachlorophene preparations in infant skin care are compared and discussed.

STERILIZATION

850. DAUPHIN, A. and others. Le magasin de matériel médical à usage unique et du pansement. **[Medical supply centre for disposables and bandages.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1979, Jan., no. 400, pp. 35-41.

Recommendations are put forward regarding the organization and management of the hospital medical supplies centre for disposables and dressings. The centre should be an independent unit; its function is to meet the users' requirements and to provide the latter with adequate information on the range of goods available. A simple filing arrangement is outlined for (i) suppliers and supplies, (ii) users, and (iii) manufacturers, and designs for order forms and a catalogue are proposed. Specific recommendations are also made with regard to distribution, storage, and stock management.

AIR HYGIENE

See also Abstract No. 854

851. RÜDEN, H. Raumlufthygienische Anforderungen und ihre Beeinflussung durch baulich-technische Massnahmen. **[Clean room air requirements and how they are affected by building and engineering measures.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 391-396.

Technical installations are necessary for meeting air hygiene requirements but if they are wrongly used they can, in spite of actual inefficiency, give a false impression of adequacy. It is important to determine the required levels of air hygiene for different hospital areas: the requirements at four different levels are set out. Hygiene standards should be based on medical requirements. The paper sets out in a series of eight tables the basic data on air hygiene for hospitals.

INSECT AND PEST CONTROL

852. BURGESS, N. R. H. and CHETWYN, K. N. **Cockroaches and the hospital environment.** *Nursing Times*, London, 1979, Feb. 15, vol. 75, no. 7, Contact, pp. 5-7.

Nearly all hospitals are infested to some extent with cockroaches which may be found at night in any area providing warmth and food. A large number of pathogenic organisms have been found to have infected cockroaches in the hospital environment, notably four strains of polio virus, a variety of bacteria and five helminths which infect man. Cockroaches often survive substances used in de-infestation, harbour the organism and return to cause repeated outbreaks of infection. Even a dead cockroach can remain a source of infection for at least 10 days after death. A project is in progress to stereotype certain strains of *Klebsiella pneumoniae* frequently isolated from cockroaches and compare them with resistant strains in patients in the same hospital. Thus, cockroaches are often a significant factor in the spread of disease.

SAFETY MEASURES

See Abstract No. 793

ACCIDENTS, GENERALLY

853. VICKERS, M. D. **Fire and explosion hazards in operating theatres.** *British Journal of Anaesthesia*, London, 1978, July, vol. 50, no. 7, pp. 659-664.

Fires and explosions can only occur when three components are assembled simultaneously: a gas which supports combustion (usually oxygen), a flammable material, and a source of ignition. The elimination of any one of these is the aim of safety precautions in this field. Antistatic precautions involve the floor, the patient, clothing and footwear of staff, the anaesthetic machine and circuits, and plastic materials. The need for antistatic precautions in various areas is discussed. Fire hazards also occur with some surgical drapes and packs and nebulizers, and in laparoscopy. The high degree of safety existing in operating theatres in the United Kingdom has been achieved by safety precautions which in some respects have been over-careful and over-expensive. Antistatic precautions applied to the breathing circuit seem to have been the crucial factor in achieving this level of safety.

854. LIGHT, S. **Staff face danger in the operating theatre.** *Nursing Mirror*, Sutton, 1979, Jan. 11, vol. 148, no. 2, pp. 20-22.

The literature on health hazards in the operating theatre is reviewed. Sources of pollution in theatres include: (i) liquid volatile agents escaping when vaporizers are being filled; (ii) leaks from anaesthetic machines and from face masks; and (iii) expired air from the patient's lungs. Preventive measures include: (i) re-filling vaporizers at the end of the day; (ii) servicing machines regularly; and (iii) using a scavenge rather than an expiratory valve. The only cure for atmospheric pollution is the use of one of three scavenging systems: (i) a passive system; (ii) an assisted passive system, using the theatre ventilation pump; or (iii) an active system using a flow inducer. Whichever system is used, gases must be transmitted to a carefully sited external discharge point through piping which incorporates a safety relief valve. Although further tests need to be done, there appears to be an increased risk of abortion and of hepatitis with anaesthetic practice and precautions should be taken to reduce pollution to a minimum.

ELECTRICAL ACCIDENTS

855. CHICKEN, E. **Electrical safety and hospital service instrumentation.** *Laboratory Practice*, London, 1979, Jan., vol. 28, no. 1, pp. 23-26.

The development of the electronic engineering advisory and maintenance service of the Northern Regional Health Authority is described. Some 80 professional staff are responsible for the preventive maintenance of a very wide range of equipment used for diagnosis, analysis, treatment, security and internal communication. Before the service was set up there was no planned policy for financing or maintaining complex electronic equipment used in hospital departments. The Northern Region Electronic Department incorporates one of the four evaluation centres set up to help supplies officers select reliable equipment. The department also evaluates new equipment for safety and performance and a number of instances when hazards have been encountered are described. All users of equipment are trained in its care and operation, and know when to call in specialist help. The Department of Health and Social Security has

issued a national policy document dealing with equipment management which follows closely the system adopted by the Northern Region in recent years.

856. HULL, C. J. **Electrocution hazards in the operating theatre.** *British Journal of Anaesthesia*, London, 1978, July, vol. 50, no. 7, pp. 647-657.

This paper examines the causes of death by electrocution and suggests a code of practice for the safer use of electrical apparatus in operating theatres. The code indicates that: (i) all electrical devices contacting the patient must conform to International Electrotechnical Commission 'CF' specifications; (ii) all mains-operated electrical devices must be earthed to the common high quality earth, and their metal enclosures connected to that earth; (iii) battery-operated devices should not be earthed, but they and their connections must be insulated to prevent accidental grounding; (iv) gloves must be worn when handling intracardiac leads and, so far as possible, kept dry; (v) mains-powered instruments must be kept out of reach of the person handling the catheter; (vi) if an ECG display shows excessive 50-Hz interference, this may indicate a mains current gradient across the patient—as many devices as possible must be disconnected and care taken not to earth the patient; (vii) when a patient with an external pacemaker is about to leave his 'protected' environment, his endocardial conductors and pacemaker must be well insulated from casual contact; and (viii) if a patient develops ventricular fibrillation, microshock must be suspected and the equipment properly checked before re-use.

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

857. SPURRING, P. W. and SHENOLIKAR, B. K. **Hazards in anaesthetic equipment.** *British Journal of Anaesthesia*, London, 1978, July, vol. 50, no. 7, pp. 641-645.

Three sources of hazards in anaesthetic equipment are examined: equipment breakdown; faulty equipment; and human error. The essential features of a scheme for ensuring that equipment is safe and reliable in use can be summarized as: (i) careful selection in the first place; (ii) proper training of the staff using the equipment; (iii) a proper system of inspection, test, calibration and servicing for all equipment, even that which is not in everyday use; and (iv) a system of replacement before breakdown occurs.

PLANNING FOR MASS EMERGENCIES

858. SMULDERS, A. J. M. Voor snelle behandeling van gewonden bij ramp: elk ziekenhuis dient in bezit te zijn van rampenplan: speciaal evacuatie laken voor noodsituaties. **[For speedy treatment of the injured in a disaster every hospital must have an emergency plan: special evacuation sheets for use in emergencies.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1979, Jan., vol. 48, no. 1144, pp. 25, 27, 29.

The first part of the paper reports a speech by Dr. Smulders at a recent meeting of the Foundation for Civil Defence and Self Protection. To cope with a disaster a hospital should produce an emergency plan covering the following aspects: an alarm and chain system whereby patients can be attended to without delays; special areas for

reception of the wounded, shock treatment and minor surgery; opening of a reserve theatre; information office for the public away from the treatment areas; keeping corridors and lifts clear of unnecessary traffic; extension of mortuary space; and changing of staff every 12 hours. Account should be taken of possible delaying factors, such as the number of operating theatres, the amount of available blood plasma and surgical instruments, the capacity of the intensive care unit and the number of anaesthetists and medical staff available for temporary surgery. The shock treatment area should be large enough to function as an intermediate station from which to send patients to other hospitals. The second part of the paper considers emergency aids, among which are: an evacuation sheet fixed underneath a hospital mattress with belts to secure the patient for quick transport: a shute made of a tarpaulin attached to a steel cable fixed at a certain angle between window and ground; and an outside emergency ladder made of anodized aluminium with 60 cm. wide rungs, 30 cm. thick rail and a stand which folds into a neat 10 by 11 cm. narrow column when not in use. The paper includes 10 pictures.

859. VERHEES, L. A. Vervoer patiënten met infectieziekte deel II: mobiel noodziekenhuis met zestig bedden. **[Transporting patients with infectious diseases, part II: a mobile emergency hospital with 60 beds.]** *Technische Gids voor Ziekenhuis en Instelling*, Amsterdam, 1979, Jan., vol. 48, no. 1144, pp. 20-22.

The paper describes a Swiss model exhibited by 'Socoraum Genève' at the eighth World Congress of the 'Organisation Internationale de Protection Civile-Genève' in Tunis in May. The emergency hospital can be assembled from a set of standard unit containers, 12 m. in length with a 9.50 m. extension, which can be stacked or placed alongside when stored or transported by trailer, train, ship or air. The floors of the units are constructed of iron with wooden boards and waterproof multiplex plates with lino or aluminium floor covering. Roofs are of fireproof cotton or nylon sheeting with a 5 cm. thick insulating layer of compressed polyurethane. Windows and doors have varnished galvanized steel frames, with dustproof windows and plastic shutters. Sanitary arrangements comprise four toilets, four showers, two washbasins and two cloakrooms. Wallcoverings are of stainless steel. Water is supplied from 300 to 500 litre stainless steel reservoirs which can be fed from the local water supply or a mobile tank. The electric installation, on 220 V., has a cable for connection with grid or generator. The paper includes six pictures showing the assembly procedure.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract No. 928

860. LESKE, M. C., SORENSEN, A. A. and ZIMMER, J. G. **Discrepancies between admission and discharge diagnoses in a university hospital.** *Medical Care*, Philadelphia, 1978, Sept., vol. 16, no. 9, pp. 740-748.

Admission screening and certification systems for use review are based on acceptance of attending physicians' admitting diagnoses. This study was conducted to: (i) compare admission and discharge diagnoses; (ii) identify the characteristics of patients and

diagnoses subject to higher rates of diagnostic discrepancy; and (iii) analyze the apparent reasons for such discrepancies. In a total of 955 discharges, diagnostic changes were found in 26.8 per cent of all admissions and were most frequent in neurological, medical and paediatric patients. The rate of change varied with patient age and length of stay and were lowest in Medicaid patients. Changes were usually from general to more specific diagnoses in related categories, with 4.3 per cent being discharged undiagnosed and 2.9 per cent with unrelated diagnoses. Major causes for discrepancies were related to clinical and laboratory findings. No evidence was found for deliberate diagnostic manipulation to gain admission or to improve financial coverage.

WELFARE OF THE PATIENT

See also Abstract Nos. 829, 891, 894-895, 904, 911, 919, 929, 931

861. PLUCKHAN, M. L. **Human communication: the matrix of nursing.** New York & London, McGraw-Hill, 1978, xi, 196pp. £5.95

The author believes that communication can be improved in three ways: (i) by increasing our appreciation and understanding of the process itself; (ii) by increasing our understanding of ourselves and our personal growth; and (iii) by improving our sensitivity to others. The content of this book has been developed to address these three objectives. Part I considers concepts, principles, basic communication theory and methodologies relating to the human communication process. Part II considers human communication concepts; principles and methodologies as applied to nursing, including the nurse-patient relationship; the reading-learning process; and management. A bibliography is included after each of the 13 chapters.

862. BALL, M. **Suicides in hospitals.** *Health and Hygiene*, London, 1978, July/Sept., vol. 2, no. 1, pp. 15-19.

Residents of certain institutions, including hospitals, have acquired a reputation for high suicide rates. To assess the justification of this reputation, all deaths from suicide occurring throughout Hertfordshire in one year were identified by means of coroners' records and through direct enquiry; those deaths occurring among the existing hospital patients were distinguished from deaths of other persons admitted to hospital following a final attempt at suicide. Among hospital patients there were seven deaths attributable to 'estimated suicide', of which two were open verdicts. One death was among mental handicap and non-psychiatric patients and six were among psychiatric patients. The latter is higher than expected on the basis of the age and sex structure of the hospital population, but probably not excessively high for a sample consisting of 3,675 mentally ill patients. The likely effects of increasing the identification and admission to hospital of high risk cases are discussed.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

863. SKEET, M. **Tapping voluntary resources in the welfare state: the practical problems.** *Royal Society of Health Journal*, London, 1979, Feb., vol. 99, no. 1, pp. 23-27.

In order to integrate the volunteer (who is not always an amateur) into the health

care team, it is necessary to have the acceptance and the co-operation of three parties: the volunteers themselves, the professionals, and the patients. The practical problems of each of these groups are considered in turn by the author who advances ideas and bases opinions on personal experience during her professional life as a nurse. Those problems of the patient are considered first in order of priority and importance.

HOSPITAL SOCIAL WORK

864. TIBBITT, J. E. **Social workers as Mental Health officers.** (Scottish Office Social Research Study) Edinburgh, Her Majesty's Stationery Office, 1978, v, 41pp. £0.90

This report sets out the findings of a study of one aspect of social work practice in Scotland, which has been carried out jointly by members of the Central Advisory Service and the Research Branch in Social Work Services Group (SWSG). It is a study of social workers acting as Mental Health Officers (MHOs) for the purposes of the Mental Health (Scotland) Act 1960, and concentrates on the part they play in the formal admission of patients to hospital under sections 24 and 31 of the Act. The investigation reported here is an attempt to examine the circumstances in which the duties of the MHO are performed in Scotland, the perceptions of the role held by social workers acting as MHOs and the problems and difficulties they encounter in carrying out these functions. An attempt has been made to look both at current practice and at more general questions relevant to this area of work. A number of points have been highlighted which should be considered if improvements are to be made both in the short-term and in the long-term development of the role.

865. POTTER, C. **Bringing heaven right down to earth ...** *Health and Social Service Journal*, London, 1979, Feb. 22, vol. 89, no. 4629, pp. 184-185.

The South Glamorgan Area Health Authority (Teaching) and the Health Care Studies Unit of the Welsh Regional Management Centre ran a pilot course for hospital chaplains to establish whether such training really would meet a need. The aim of the 10-week residential course based on two five-week blocks was to help chaplains to understand the setting in which they were expected to perform their role and how they could contribute to the overall well-being of patients. More than 30 people besides the main tutors gave lectures. Course members increased in confidence as they discovered how many staff of all disciplines and opinions recognized the chaplain's role. They continue to report on the benefits they received from the course.

TERMINAL CARE

866. BAYLES, M. D. and HIGH, D. M., editors. **Medical treatment of the dying: moral issues.** Cambridge, Mass., G. K. Hall & Co., 1978, [v], 187pp. $13.95

The social problems of medical treatment for the dying are considered in these eight papers written by contributors from various disciplines. Aspects considered include: the rights and responsibilities of patients and doctors; dealing with death; the concept of brain death; death, dying and the zealous phase; quality of life and care;

and natural death and public policy. The papers were originally presented to a Conference on Moral Issues of Moral Treatment of the Dying held at the University of Kentucky in October 1974. A bibliography (pp. 180-186) and notes on contributors are included.

867. STODDARD, S. **The hospice movement: a better way of caring for the dying.** London, Jonathan Cape, 1979, xviii, 266pp. £5.95

This book describes the development of hospice care for the terminally ill. After considering the treatment of the dying in earlier times it describes the work of St. Christopher's Hospice near London, and goes on to discuss similar hospices in the United States. Three appendices cover drug control of common symptoms, American equivalents to medicines in St. Christopher's drug chart, and a pain-comfort chart for the Hospice of Morin. A bibliography is included (pp. 247-358).

HOSPITAL CARE

See also Abstract Nos. 792, 809, 826, 839, 909-912, 925

868. SNOWDEN, D. **Decubitus ulcer.** *Nursing Mirror*, Sutton, 1979, Feb. 1, vol. 148, no. 5, pp. 22-25; Feb. 8, vol. 148, No. 6, pp. 26-30.

This report describes the incidence, methods of prevention and treatment of pressure sores within the medical unit of Chapel Allerton Hospital. A record card was kept for each of 210 patients suffering pressure sores, or decubitus ulcers, over a three-year period. Sixty patients had sores on admission, 24 involving deep tissue. Changes in condition or treatment of the sores were noted on the card. The following methods of preventing decubitus ulcers are employed: (i) washing pressure areas with soap and water and applying a simple barrier cream; (ii) turning patients two-hourly, lifting them correctly and aiding active exercise; (iii) using sheepskin rather than Sorbo rings; (iv) using tilting or large cell ripple beds, and occasionally a water bed; (v) the use of bed chairs and Buxton geriatric chairs; and (vi) the use of bed cradles. A number of pharmacological treatments and their use and effectiveness for different types of sores are described in detail. These include viacutan, eusol, zinc and castor oil, madecassol, and Karaya gum. Saline baths are beneficial for all types of sores. Preparations containing antibiotics should only be used under medical advice. The unit is reasonably successful in treating decubitus ulcers, and most patients whose sores do not improve with treatment are suffering from a terminal illness.

869. SPRI. Gruppvård: ett alternativ? **[Group care—an alternative?]** (Projekt 3053, Spri Rapport 4/78) Stockholm, Spri, 1978, 77pp.

The unsatisfactory relations which sometimes exist between patients and hospital staff at ward level indicate a need for a change from the rounds system which came into practice in the 1950s and which provides patients with less care and attention than before. Group care is an alternative system currently being introduced in which both patients and staff on a ward are divided into groups and each staff group is allocated to a certain patient group. The patient in each group has fewer people caring for him than

in the rounds system which results in more personal care and makes the patient feel more secure. The need for good planning, communication and exchange of information and knowledge are discussed. Examples of group care plans and forms are included together with a bibliography (pp. 58-60).

870. CABBAN, P. T. and CASWELL, J. R., compilers. **Hospital quality control: a users' manual.** Crow's Nest, N.S.W., Community Systems Foundation (Australasia), 1978, [v], 130pp.

This manual aims to provide an outline of the processes involved in the establishment of a quality control scheme. The basic methodology incorporated in the manual was developed by the Commission on Administrative Services in Hospitals. Aspects covered include: characteristics and design of the scheme; implementation; analysis of results; revision of criteria; and use of control periods. Sample assessment check sheets are provided for the various hospital departments together with tables of results and random numbers.

871. ESCOVITZ, G. H. and others. **The effects of mandatory quality assurance: a review of hospital medical audit processes.** *Medical Care*, Philadelphia, 1978, Nov., vol. 16, no. 11, pp. 941-949.

A study of 17 hospitals in the Greater Delaware Valley region was undertaken to determine whether hospitals which had taken part in an earlier effort to introduce medical audit differed from a matched group which had not. The hospitals varied in size, type of location and degree of involvement in teaching. Data were collected and analyzed regarding the administrative organization of the audit, the number of audits performed, the criteria employed and how the findings were used. No significant differences were found between those hospitals which had participated in the voluntary audit project and those which had not. There were wide variations among hospitals as to the use of medical audits, the criteria applied, and the effect the findings had on the hospital's organization. Thus, despite the requirements of the Joint Commission on Accreditation of Hospitals, the process of medical audit in hospitals is not very far advanced.

872. NICHOLLS, M. E. and WESSELLS, V. G., editors. **Nursing standards and nursing process.** Wakefield, Mass., Contemporary Publishing, 1977, x, 164pp. $7.95

The aim of this book is to help the student of nursing to understand: the language of standard setting; the selected frames of reference in which this terminology is used; the factors affecting standards; the use of nursing process; quality control; and their application in standard setting and maintenance at the direct care level of practice. The first section of this book introduces the changing vocabulary of nursing standards and quality assurance schemes; the second section considers the development of standards at the practice level; the third section considers the process of standard setting; and the fourth section is devoted to a series of case studies with discussions of standards and quality assurance schemes written by nurses and teachers in a variety of settings.

873. HAUSSMANN, R. K. D. and HEGYVARY, S. T. **Monitoring quality of nursing care. Part III. Professional review for nursing: an empirical investigation.** (DHEW Publication No. HRA 77-70) Washington, D.C., U.S. Government Printing Office, 1977, vi, 101pp.

This report covers the third phase of a study performed under contract with the Division of Nursing by the Rush—Presbyterian—St. Luke's Medical Center, Utah, and the Medicus Corporation. It investigates the relationship between nursing process and patient outcomes based on the process-monitoring methodology developed and tested during the previous phases of the study. The third section of the report presents details of the methods and findings of the study. Chapter 2 reviews the literature related to professional standards review. Chapter 3 explores the issues in applying the PSRO concept to nursing and presents the conceptual review framework chosen for field testing. Chapter 4 focuses on the research design and instrument development particularly for outcome screening. Chapter 5 presents findings and interpretations of the pilot application of the review methodology. A concluding section discusses implications and areas for further study. The report is supported by appendices presenting the outcome criteria, process criteria and supplemental data. Ten tables supplement the information together with three figures. A bibliography of 32 items is included (pp. 40-41).

874. RAMSAY, T. E. and WRIGHT, R. D. **Impacts of health maintenance organization growth on community health care costs.** *Socio-economic Planning Sciences*, Oxford, 1978, vol. 12, no. 5, pp. 241-249.

This paper presents a model of health maintenance organization (HMO) growth, traditional health delivery system response, and total community health care costs. Simulations using a range of assumptions about the response of government and the traditional sector to HMO growth suggest three conclusions: (i) HMO growth reduces total community health costs, but a substantial fraction of HMO subscribers' savings is added to the cost of other sector subscribers; (ii) HMO cost savings depend as much on HMO control of inflation rates as on control of hospital use; and (iii) while HMOs can have significant impact even when they share hospital resources with the traditional sector, HMOs must control captive hospitals in order to achieve all of their potential savings, growth and community impact.

875. LUFT, H. S. **How do HMOs achieve their 'savings'?** *Hospital Medical Staff*, Chicago, 1978, Nov., vol. 7, no. 11, pp. 8-17.

Health maintenance organizations (HMOs) have been suggested as a method of stopping spiralling medical costs. A comprehensive review of studies published since 1950 supports the claims and expectations that medical care expenditures are lower from HMO enrollees than for people with conventional insurance coverage; total costs (premium and out-of-pocket expenses) are 10 to 46 per cent lower. Most of this difference is due to lower hospital use, and is not attributable to the length of stay (which on average is about the same) but to a generally lower admission rate.

876. WILLIAMSON, J. W. **Assessing and improving health care outcomes: the health accounting approach to quality assurance.** Technical editor: Renate Wilson. Cambridge, Mass., Ballinger, 1978, xxiii, 327pp. £10.40

This book explores the concepts and methods of an outcome approach to quality

assurance in ambulatory and hospital care. The aim of the book is to demonstrate the feasibility and potential of using outcomes as the basic assessment measures in quality assurance in the health professions and it illustrates this approach with the early results of assessment studies of patient care over a 10-year period. The book is in three parts: part 1 considers the conceptual considerations of basing quality assurance on the outcomes of care; part 2 presents a description and the results of an outcome-based quality assurance strategy; and part 3 considers the implications of using an outcome approach for the development of quality assurance. Two appendices present a health status questionnaire and selected data on the costs of health accounting.

DISCHARGE OF PATIENTS

See Abstract No. 860

HOME CARE, AFTER-CARE

See also Abstract No. 914

877. CLARKE, F. **Hospital caring without walls ...** *Health and Social Service Journal*, London, 1979, March 29, vol. 89, no. 4634, pp. 309-310.

After six months of preparation the Peterborough Hospital at Home (HAH) pilot scheme admitted its first patients in November 1978. A nursing co-ordinator is responsible for the day-to-day running of the scheme, taking into account the needs of the patients and resources available. A medical social worker is employed to assess basic needs which can be met from other sources. The day-to-day care of the patients is the responsibility of nursing sisters who carry out care and treatment or supervise the work of patient aides, who remain with the patients for as many hours of the day as necessary. On admission a dossier similar to hospital notes is made up; one section is kept at the patient's bedside and the other at HAH headquarters. From the 15 patients so far admitted the scheme has been judged successful by patient, doctor and HAH staff. Public response has also been reassuring.

878. GAY, P. and PITKEATHLEY, J. **When I went home ... a study of patients discharged from hospital.** London, King Edward's Hospital Fund for London, 1979, [vii], 82pp. £3.00

This study was supported by grants from Oxford Regional Health Authority and King Edward's Hospital Fund for London, and considers the problems of patients discharged from hospital and the possible involvement of volunteers in the care of such patients after their discharge. The total number of patients interviewed was 257 and the problems they encountered are discussed. A select bibliography is included.

SPECIAL DEPARTMENTS

OPERATING SUITES

See Abstract Nos. 784, 854, 856

ANAESTHESIA

See Abstract No. 857

PHARMACY

879. Rees, J. A. and Moss-Barclay, C. **A survey of the role of staff pharmacists in the hospital pharmaceutical service.** *Journal of Clinical Pharmacy*, Oxford, 1978, Dec., vol. 3, no. 4, pp. 239-245.

A questionnaire designed to collect information about the daily role and responsibilities of staff pharmacists was distributed to all such pharmacists in one region. The answers revealed that there was a wide range of age and experience amongst staff pharmacists, the largest number being between 21 and 29 years of age and employed in the hospital pharmaceutical service for about five years. Staff pharmacists could be classified according to their work by: (i) the extent of responsibility held; and (ii) the size and type of establishment where they were employed. The majority of respondents spent more than 90 per cent of their working time in individual pharmacy departments of varying sizes, those in smaller pharmacies holding higher levels of responsibility. The number of hours spent in a week on various types of work were examined, and from this, two distinct classifications of work and responsibility were revealed. The actual role of the staff pharmacist may sometimes differ from, but in general does not oppose, the role laid down by the Noel Hall Report of 1970.

880. La distribution des médicaments à l'hôpital. 1 Partie. **[Drug distribution in hospitals. Part 1.]** *Techniques Hospitalières*, Le Kremlin-Bicêtre, 1979, Jan., no. 400, pp. 61-72.

Following some general observations on the need for safety in the distribution of drugs in the hospital and the desirability of a system which provides easy stock control, systematic rotation, a reduction in the number of drugs, and easy and safe re-ordering, the author proposes a design for a standard drug cupboard which would hold enough drugs for a unit of 100 to 200 beds. This cupboard is two metres high, one metre wide, and 0.40 metres deep. It has 10 shelves and contains a locked chest for dangerous drugs.

LABORATORIES

See also Abstract No. 844

881. World Health Organization. Regional Office for Europe. **The role of the hospital laboratory in public health: report of a working group, Stockholm, 8-12 May 1978.** (ICP/ATH 004) Copenhagen, WHO Regional Office for Europe, 1978, [iii], 15pp.

This working group on the role of the hospital laboratory in public health brought together temporary advisers from 11 countries to define the role of the hospital laboratory in public health and its collaboration with the public health laboratory network, to assess present and future trends and to consider how all types of health

laboratory service might be rationalized. There are four sections: functions of hospital laboratories; development of hospital laboratories; collaboration and co-ordination; and recommendations. A list of participants is included.

882. BÜTTNER, H. Kommunikation zwischen Laboratorium und Klinik. **[Communication between the laboratory and the clinician.]** *Krankenhausarzt*, Karlsruhe, 1978, Dec., vol. 51, no. 12, pp. 887-888, 890.

New developments in automation, quality control and electronic data processing have led to great changes on clinical chemistry. The speed and accuracy with which large numbers of analyses are carried out have however led to an information crisis which has made communication between laboratory and clinician more difficult. This paper puts forward proposals for improving this communication. Examples are given of some of the causes of poor communication as well as of optional means of data presentation.

883. MAKEY, D. G. and others. **A computerized reference laboratory.** *Medical Instrumentation*, Arlington, Va., 1979, Jan./Feb., vol. 13, no. 1, pp. 46-50.

The Reference Laboratory for the Veterans Administration Co-operative Urological Research Group, Minneapolis VA Hospital, has established a computer system for handling data on serum samples from 26 hospitals participating in randomized clinical trials of treatments for prostatic cancer. It consists of three remote terminals connected to the hospital's computer. A teletype and an optical mark card reader are used by secretaries and technologists for record initiation and entry of laboratory test data into records found on computer dish files. A videoscope is used for high-speed scanning of patient records. Reports of these analyses are generated on a weekly basis and posted to the hospitals. A magnetic tape copy of the records is sent to the statistician's office on a demand basis. The system eliminates errors in calculations and data transfer, permits rapid editing, increases ease of laboratory management, and improves quality control.

BLOOD TRANSFUSION DEPARTMENT

884. CHALMERS, D. G. **Computers in the service of haematology.** *Hospital & Health Services Purchasing*, London, 1979, Feb., pp. 52, 54, 56.

A computerized system for the cytology section of the haematology laboratory has been developed at Addenbrooke's Hospital, Cambridge, with the support of the Department of Health and Social Security. Request cards for tests are given an accession number and passed on to the data preparation room. Here the information is entered on to a visual display unit carrying patient details and the test required. Subsequent requests for the same patient are linked to any earlier requests on the computer's patient file. A worklist of the next 20 bloodcounts to be made is printed by the computer. Specimens are fed through the blood counting machine and results printed out and vetted by a member of the medical staff. If the results are approved, a cumulative report on each patient is produced. Results more than six months old are stored on microfiche. The system has produced a quantity of reliable information: techniques are now being considered to make it more quickly available.

DIAGNOSTIC X-RAY DEPARTMENT

885. SPRI. Datortomagrafi av kroppen: användning, ekonomi, teknik. **[Computerized tomography of the body: clinical use, economics and technical aspects.]** (Spri Rapport 15/77) Stockholm, Spri, 1977, 63pp.

This report considers the use of computerized tomography in Norway. Aspects covered include: applications, both general and specific; economic features; and techniques. Six appendices list: definition of terms; clinical work with a computerized tomograph for the whole body; costs for computerized tomography of the body; measurements of the absorbed radiation dose; summary of technical data; and computerized tomography in planning radiation treatment.

886. ABERDOUR, K. R. **Equipping an X-ray department.** *British Journal of Clinical Equipment*, London, 1979, Jan., vol. 4, no. 1, pp. 22, 24-26, 28.

It is difficult to decide on the right X-ray equipment to buy because of the rapid developments taking place. Of the recent advances and indications of future opportunities, this paper touches only on those topics likely to interest a small general department. They are: daylight processing; cassetteless radiography; miniaturization; 100 mm. film; screening tables; urography; casualty; radiation protection; mobile units; mobile image intensifiers; X-ray intensifying screens; and ultrasound.

887. STOCKING, B. **X-rays highlight the doctor's dilemma.** *New Scientist*, London, 1979, Jan. 11, vol. 81, no. 1137, pp. 84-87.

The use of computed tomography (CT) in brain scanning provides undisputed benefits. Body scanning has caused much more controversy because other acceptable techniques are available. Initial clinical evaluation indicates that the main application of CT scanning on the body is in the more precise information it gives in cancer cases. Even here its value in relation to cost is questionable in view of the limited resources of the National Health Service (NHS) and the need to make decisions on the allocation of those resources. The advent of the body scanner has also raised the question of the role of philanthropy in the NHS. As a result of official reluctance to purchase body scanners, of the 22 body scanners in the United Kingdom, seven were donated by philanthropists and four by public appeals. Philanthropic gestures and public appeals can be very beneficial to the NHS, but must be integrated into the overall policies and needs of the NHS. It is suggested that a committee of representatives from the Department of Health and Social Security, NHS, Medical Research Council and from industry should be appointed to manage the evaluation and introduction of health technologies.

888. WORTZMAN, G. and HOLGATE, R. C. **Reappraisal of the cost-effectiveness of computed tomography in a government-sponsored health care system.** *Radiology*, Easton, Pa., 1979, Jan., vol. 130, no. 1, pp. 257-261.

In 1975 it was estimated that installation of a computed tomography (CT) brain scanner at Toronto General Hospital could save two million dollars a year, which could then be reallocated within the hospital's health care programme. It soon became apparent that the statistics upon which this conclusion was based could be interpreted in many ways. In this paper the cost-effectiveness of the operation of the CT scanner is re-evaluated. It shows that although savings are possible, budgetary policies and

anomalies prevent the realization of those savings and, in fact, produce either increased costs or decreased access of needy patients to hospitals. True savings can be achieved by proper use of existing facilities, and then only in the future, not in the current calendar or fiscal year.

889. RHEA, J. T. and ST. GERMAIN, R. P. **The relationship of patient waiting time to capacity and utilization in emergency room radiology.** *Radiology*, Easton, Pa., 1979, March, vol. 130, no. 3, pp. 637-641.

This study conducted in the radiology section of an emergency department at Massachusetts General Hospital, quantifies the relationship between waiting time and use of facilities. The data needed for analysis include patient waiting time, patient volume, the time required for different types of examination, and the technologist and equipment capacity. Average waiting time was related to both required examination time and available technologist time. The average time taken for each examination was 18 minutes, or between 259 and 1,062 minutes for each daily shift over 23 days. The average waiting time was 8.3 minutes with a maximum of one hour. If the rate of use was increased to save costs, the waiting times for patients would become unacceptable. Use can only be decided by fixing an allowable waiting time. It is possible to gain a higher use rate and lower costs if the volume of work is less variable. Although this is difficult to achieve in an emergency room, times which tend to be slack can be used for elective examinations of in-patients.

OCCUPATIONAL THERAPY DEPARTMENT

890. SACKETT, J. **What of the future? Occupational therapy in psychiatric hospitals and the community.** *British Journal of Occupational Therapy*, London, 1979, Feb., vol. 42, no. 2, pp. 46-47.

The aim of occupational therapy in psychiatry is to help the patient come to terms with his illness and regain his place in the community. Psychiatric units and day hospitals are often limited in the degree to which patients can benefit from occupational and other therapies or, conversely, occupational therapy units are situated in hospitals not geared to the needs of the psychiatric patient. Psychiatric units or hospitals with short term patients need to have a 'day activity' area catering for a wide range of aptitudes. The type of work provided should also be geared to the patient's previous job and social background. Group activities should help the patient towards social re-adjustment. Voluntary workers can often help to build bridges between the hospital and the community and psychiatric community nurses undoubtedly save many patients from admission. However, there is an urgent need for a national development plan for the treatment of psychiatric patients as facilities are very unevenly distributed over the country as a whole.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract Nos. 843, 915-919

891. MCKENNA, S. E. **A new lease of life: a positive approach to helping the stoma patient.** *Nursing Times*, London, 1979, Feb. 22, vol. 75, no. 8, pp. 320-323.

In Britain today there are about 100,000 people who have undergone an operation

resulting in permanent colostomy or ileostomy and the number is increasing daily. The patient should be prepared in every way by the medical and nursing team for the change created by the colostomy, thereby reducing the risk of emotional and psychological disturbances. After the operation the patient should be taught gradually to take care of the stoma so that his progress is without complications. A number of types of stoma are described. After discharge, the patient may see a stoma therapist, although these are few, to discuss his appliance, his diet and any other problems. An early return to work and leisure activities is a high priority in rehabilitation. Elderly patients often require continuing help from community nurses. The Ileostomy Association and the Colostomy Welfare Group provide additional support for those who need it.

892. IMLAH, N. and AKHTER, M. **Bitter-sweet success.** *Nursing Mirror*, Sutton, 1979, Feb. 1, vol. 148, no. 5, pp. 18-20.

The addiction unit at All Saint's Hospital, Birmingham is the drug dependency treatment centre for the West Midlands Region, treating both alcoholism and drug addiction. All management decisions concerning, for example, the introduction of a new treatment programme, the overall management of patients and the development of teaching and research, are made by a multidisciplinary group which meets regularly. The clinical management team includes representatives from outside bodies and deals with the staff's therapeutic role in their relationship with patients. Admissions policy varies according to the type of problem. Motivation for treatment is tested by a simple token system, adjusted to suit the condition of the individual patient. Schemes of withdrawal or controlled maintenance are used for both types of addiction. When the best form of treatment has been worked out and if the patient is co-operative, he may be discharged to out-patient follow-up with a contract arrangement.

INTENSIVE CARE UNITS

893. DIETZEL, W. Anordnung der Entsorgung und Geräteaufbereitung auf Intensivtherapieeinheiten. **[A system for the disposal of materials and instrument preparation in intensive care units.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 399-401.

The basic principle is that transport routes for clean and dirty supplies should not cross. A sketch plan is presented of an intensive care unit in the form of an arch with the six single patients' rooms forming a semi-circle to give full observation from the central area. Clean materials enter patients' and other rooms from the central area while dirty materials are removed via a corridor which runs round the outside of the 'arch'. The same principle of separating the clean from the dirty side applies to the area for instrument preparation: this is shown in diagrammatic form.

894. JUNKER, L. Empati som et middel anvendt i den psykiske pleje af den intensive patient: I; Pårørende føler sig lige så hjælpeløse som intensivpatienten. **[Empathy as an adjunct in the psychological care of intensive unit patients: Part I; relations feel as helpless as patients.]** *Sygeplejersken*, København, 1978, Dec. 13, no. 49, pp. 22-25.

Intensive care patients fall into three categories: acute observation and treatment

patients, acute traumatic admissions, and patients whose condition has deteriorated from other wards. The ward attracts a particularly highly qualified type of nurse who becomes responsible for a wide range of technological equipment. The time to look after the range of tasks has to be taken from the personal care of the patient and consequently nursing risks becoming de-humanized. A patient recovering from unconsciousness in a respirator is anxious, afraid of dying, and fearful of lack of communication with staff and his family. Intensive care ward staff must exercise empathy and put themselves in the patient's and his relatives' place in their choice of words and actions.

895. JUNKER, L. Empati som et middel anvendt i den psykiske pleje af den intensive patient: II; Plejepersonalet skal umärkeligt indleve sig i patientens situation. **[Empathy as an adjunct in the psychological care of intensive unit patients: Part II; nursing staff must familiarize themselves with the patient's position.]** *Sygeplejersken*, København, 1978, Dec. 20, no. 50, pp. 16-20.

Empathy has been subdivided by R. L. Katz into simple empathy (identification with another person) and sophisticated empathy (alternation between subjectivity and objectivity). The intensive care nurse must apply sophisticated empathy in the service of improved mental care of the critical patient. Aids to this process involve the collection of data, definition of the patient's needs, and the planning, execution and evaluation of care. The nurse must not over-interpret the patient's needs and problems, nor engage herself in them so much as to be unable to free herself from them after work. The patient must meet a calm, confidence-inspiring staff anticipating his own and his relations' needs and openly and honestly communicating to him both verbally and non-verbally. The intensive care unit at Herlev Hospital applies modified primary nursing, whereby the entire care of a patient is the responsibility of one nurse for eight hours a day (instead of the 24 originally envisaged). New staff in an intensive care unit require a familiarization period to get used to the demands made on them. There are 37 references (eight in English).

896. MACKINTOSH, A. F. and others. **Hospital resuscitation from ventricular fibrillation in Brighton.** *British Medical Journal*, London, 1979, Feb. 24, vol. i, pp. 511-513.

The overall results of 3½ years treatment of ventricular fibrillation secondary to ischaemic heart disease in the Royal Sussex County Hospital were received. Records of all patients who were brought to hospital by resuscitation ambulances or who were admitted to the coronary care unit from any source were analyzed. Of the 174 patients who developed ventriculation, 87 (50 per cent) were discharged. The survivors included 13 out of 61 patients (21 per cent) in whom fibrillation was secondary to cardiogenic shock or severe left ventricular failure. The presence of resuscitation equipment and nursing staff trained to use it in the general wards and emergency areas ensured a uniformly high success rate throughout the hospital, similar to that achieved in the coronary care unit. Prompt defibrillation in the general wards and the accident and emergency department may improve overall survival.

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See Abstract Nos. 876, 898

CASUALTY AND ACCIDENT

See also Abstract Nos. 845, 889, 896, 902

897. CSÉPÁNYI, A. A sürgösségi betegfelvételi és betegellátó osztály hatása a kórházi ellátásra. **[Impact of the emergency admission department on hospital care.]** *Egészségügyi gazdasági szemle*, Budapest, 1978, Sept., vol. 16, no. 3, pp. 320-327.

The Szolnok County Hospital, Hungary, has established an emergency admission and nursing department to provide a new method of patient care. The new 20-bed emergency unit is well equipped with diagnostic and therapeutic equipment. It has succeeded in establishing excellent contacts with the local organization of the National Ambulance Service and has concentrated the primary care of urgent cases in one place. The new system has altered the composition of the clinical departments' patient turnover and has modified the different nursing duties of the departments. The number of patient transfers among the clinical departments has fallen by half.

898. ULLMAN, R. and others. **Impact of a primary care group practice on emergency room utilization at a community hospital.** *Medical Care*, Philadelphia, 1978, Sept., vol. 16, no. 9, pp. 723-729.

The emergency room at the 375-bed Genesee Hospital, Rochester, N.Y., provides 24-hour services in the traditional specialties. Annual visits have increased as elsewhere. In January 1972 the Genesee Health Service, a group practice of salaried primary care physicians, was established to replace the primary care clinics of the out-patient department. The primary care group appears to have effected a substantial reduction in paediatric emergency room use. To a lesser extent, use by former clinic users among adult patients was also reduced. These reductions, however, created only modest impact in the context of the hospital's total emergency room use, owed in part to the relatively small size of the patient population who formerly had depended upon the hospital for primary care.

DAY HOSPITALS

899. SCOBIE, W. G. and GARRAWAY, W. M. **Day case surgery for children.** *Nursing Times*, London, 1979, Feb. 8, vol. 75, no. 6, pp. 252-254.

A study was carried out in the North Lothian District to find out more about the home background of children chosen on clinical grounds for day case surgery. Most of the children came from two areas containing two different social classes. Ninety-six per cent of the total were accompanied by their mothers, most of whom stayed at the hospital all day. The community nursing service found that 18 per cent of the children were not

recovering well at home. Five per cent of home conditions in one localized area were unsuited for post-operative care, but no child had to be re-admitted. Information on the child's social and domestic background provided by the general practitioner at the time of referral should be taken into account when deciding whether to treat a child on a day care basis.

CHEST

See Abstract No. 911

INFECTIOUS DISEASES AND ISOLATION

See also Abstract No. 921

900. DEMETRIOU, A., THORPE, M. and FORREST, T. **A secure isolation unit in Manchester.** *Nursing Times*, London, 1979, Feb. 15, vol. 75, no. 7, pp. 274-276.

A special unit has been set up at the Monsall Hospital, Manchester, to deal with patients suspected of having imported infections such as Lassa, Marburg or Ebola fevers. The ambulance crew bringing such a patient to the hospital have disposable equipment and protective clothing and are accompanied by a police escort. Patients and relatives have the special procedure explained to them to avoid undue alarm. Two nurses wearing protective clothing are on duty in the unit, which contains two Vickers-Trexler negative pressure plastic isolators. The supply isolator is kept stocked with a 24-hour supply of bed linen, disposable cutlery and medical instruments. The patient is sealed inside the bed isolator and special suits are worn by those attending to them. All waste materials from the isolator are sealed in plastic bags and incinerated. When a patient has been cleared, he recovers in an isolation room and the isolator is disinfected. Efforts are also made to trace contacts made by the patient on his journey home from West Africa, where these fevers originate.

901. ALEXANDER A. Die bauliche Gestaltung von Infektionsstationen. **[The design of isolation wards.]** *Krankenhaus*, Stuttgart, 1978, Oct., vol. 70, no. 10, pp. 390-391.

This paper deals generally with the requirements of an infectious diseases unit: it does not cover the extra precautions needed for such specially dangerous diseases as smallpox and Lassa fever. Patients' rooms should be single or double and patients sharing a room should have the same infections. Only staff concerned with the care of patients should enter the unit. Visitors are not admitted: they can see patients only through the window and speak to them by telephone or two-way call system. Basic requirements are: staff air-lock; sanitary equipment and air-lock for patients' rooms; clean and dirty work rooms; clean kitchen; dirty washing-up room; doctors' room; staff room; staff toilet and washing facilities; and sluice and instrument room. For a large unit (approximately 30 beds) the following are additionally recommended: bed disinfection room; discharge air lock with dirty side, shower, and clean side; reception room; bed store; laboratory; special examination and treatment rooms; doctors' room for overnight stay; office; and visitors' toilet accessible from outside.

CHILDREN

See also Abstract Nos. 785, 846, 898-899, 931

902. THOMAS, C. J. and PHILLIPS, D. R. **An ecological analysis of child medical emergency admissions to hospitals in West Glamorgan.** *Social Science and Medicine*, Oxford, 1978, Dec., vol. 12, no. 3/4D, pp. 183-192.

This study investigates geographical and social variations in the quality of health within a limited area rather than on a national or regional scale. Information was collected within the West Glamorgan Area Health Authority on 621 children admitted to hospital as emergency cases between July and December 1976. A statistical analysis was carried out on the scale of 72 urban wards and rural parishes in the county. The method used to relate the incidents of eight types of child ailments to 26 variables representing the residential and social environment of West Glamorgan is described. High admission rates were associated with concentrations of local authority housing estates, although the social life style rather than the housing conditions, which were good, was judged to be significant. In addition, poor residential areas with substandard housing and low status occupations also produced higher admission rates. The significance of two other factors, namely, access to and use of medical facilities by spatially or socially distinct groups also needs to be investigated in a study of this kind.

903. BOUCHARD, F., FLAVIGNY, C. and KREISLER, L. La psychiatrie à l'hôpital pédiatrique. **[Psychiatry in a children's hospital in France.]** *Hôpital à Paris*, Paris, 1978, Nov./Dec., no. 48, pp. 555-559.

The authors propose that psychiatric treatment for children in the Saint Vincent de Paul Children's Hospital should be re-organized. There should be an out-patient section which would allocate psychiatrists and psychologists to the various hospital departments, to provide: psychological exploration and psychiatric care for all patients considered to be suffering from psychosomatic disorders; psychiatric opinions in any discussions prior to the discharge of an adolescent who has attempted to commit suicide; and participation in the prevention and treatment of psychological disturbances associated with the hospital stay. There should also be a small in-patient unit for children and adolescents with psychosomatic disorders. In addition, there would be a teaching function, and close links would be maintained with the local inter-sector which is responsible for children suffering from psychiatric disorders.

904. ROSKIES, E., MONGEON, M. and GAGNON-LEFEBVRE, B. **Increasing maternal participation in the hospitalization of young children.** *Medical Care*, Philadelphia 1978, Sept., vol. 16, no. 9, pp. 765-777.

Parents have not taken advantage of liberalized visiting hours introduced to reduce the harmful emotional effects of separation for young children. The study reported here sought to increase mothers' participation in their children's care by overcoming some of the psychological barriers believed to exist. The mothers of 48 children aged one to five years admitted for elective surgery were divided into experimental and control groups. Mothers in the experimental group had an extra half-hour session in a pre-admission interview focusing on visiting, and specific suggestions were made about frequency and timing of visits, as well as the role of the mother during her visits. Meet-

ings were held with the nursing staff to enlist their support for this change in visiting patterns. Results indicate that length of visits, timing of visits and behaviour during them were all significantly modified for the experimental group. In contrast, the nurses did not significantly change their relationship with the mothers or children. The clinical possibilities and limitations of such a programme are discussed.

GERIATRICS AND LONG-STAY

905. FOLTYN, P. Die Pflege des alten Patienten im Krankenhaus. **[The care of the elderly patient in hospital.]** *Deutsche Krankenpflege-Zeitschrift*, Stuttgart, 1978, Nov., vol. 31, no. 11, pp. 588-590.

The views on the care of the elderly in hospital put forward in this paper are based on experience in a nursing home for elderly patients from various hospital departments. Among the special points stressed are the following: the elderly react more slowly; they are sensitive to noise; they need special support in bed; their appetite needs to be tempted by a wider choice of food; it is especially important that the effort should be made to explain to the patient what is going on; the nursing of the elderly is much more demanding on ward staff; and the fear of possible or approaching death requires a sympathetic approach by nurses.

906. WOODS, D. **Baycrest Centre for Geriatric Care.** *Canadian Medical Association Journal*, Ottawa, 1978, Sept. 9, vol. 119, no. 5, pp. 511-514; Sept. 23, vol. 119, no. 6, pp. 625-633; Oct. 7, vol. 119, no. 7, pp. 812-818.

Baycrest Centre for Geriatric Care, Toronto, comprises five elements: Jewish Home for the Aged, Baycrest Hospital, Baycrest Day Care Service, Baycrest Terrace, and the Joseph E. and Minnie Wagman Centre. The Jewish Home for the Aged provides three levels of care: residential, medium and heavy nursing, and special care for those with chronic or terminal illness. Baycrest Hospital provides chronic care and rehabilitation, as well as special clinical services. Baycrest Terrace is an 11-storey building of self-contained flats with 230 residents. The Wagman Centre is a social, cultural and recreational facility. The final part of the paper presents staff and residents' attitudes towards this attempt to provide integrated geriatric services.

907. PIPER, M. and HODKINSON, H. M. **Prediction of outcome of patients admitted to a geriatric department.** *Age and Ageing*, London, 1979, Feb., vol. 8, no. 1, pp. 36-40.

The reliability of a clinical prognosis of outcome after six weeks was investigated by studying 1,092 consecutive admissions to the geriatric department at Northwick Park Hospital, Harrow. The prognosis was made within one day after admission and was limited to three possibilities: (i) discharge within six weeks; (ii) death within six weeks; or (iii) a stay in hospital of six weeks or longer. There was a high accuracy rate for the prediction of death (81.6 per cent correct), and of discharge (71.2 per cent correct), but a much poorer success rate for prediction of stay beyond six weeks. Explanations for discordant results were sought. The majority of the large number of unpredicted deaths were caused by patients dying of a disease which developed after admission. Other reasons were a worsening of the disease present at admission and failure to respond to

treatment. It is always difficult to assess the prognosis of elderly patients, but nevertheless it forms an important basis for management and further study may improve accuracy.

908. SPRI. Personaldimensionering inom somatisk långtidsvård. **[Personnel in somatic chronic care departments.]** (Projekt 3030; Spri Rapport 8/77) Stockholm, Spri, 1977, 44pp.

This report describes a method of investigation designed to be used by county councils and other medical care authorities. It aims at providing an overview of the staffing situation at all somatic chronic care departments so that guidelines for staffing policies can be established. The investigation method is outlined and experience gained from the application of the method of investigation in three county council areas shows the method to be of practical use.

909. MCCARTHY, M. and MILLARD, P. H., editors. **Management of chronic illness: papers from a seminar.** London, King Edward's Hospital Fund for London, 1979, [x], 91pp. £3.00

The nine papers collected in this volume consider the problems involved in the management of chronic illness. Aspects considered include: care of the elderly patient with dementia; nursing patients; community nursing services; ethics and expectations; rehabilitation; the impact upon the family; the American viewpoint; and a retrospective analysis of the problems discussed during the seminar. A bibliography is included (pp. 79-85).

CANCER

910. TIFFANY, R., editor. **Oncology for nurses and health care professionals. Vol. 2: care and support.** London, Allen & Unwin, 1978, 257pp. £7.50

This book aims to provide a comprehensive introduction to oncology for nurses and other health care professionals. It includes chapters on psychological effects of cancers and their treatments, communication with patients and relatives, nutrition, the planning and delivery of nursing care, rehabilitation, the management of pain, terminal care, home care and services available for cancer patients. A list of references is given at the end of each chapter.

NEUROLOGY AND NEUROSURGERY

See Abstract No. 930

CARDIOLOGY

See also Abstract No. 896

911. Arbejdsopgaverne ved klinisk fysiologisk afdeling, Odense Sygehus: øverst står patientens behov og samarbejdet. **[The work of the clinical physiological unit, Odense Hospital: top priorities are patient needs and staff co-operation.]** *Sygeplejersken*, København, 1978, Nov. 15, no. 45, pp. 12-16.

From its beginnings in a basement in 1963, with a staff of four and 316 patients a

year, the clinical physiological department at Odense Hospital now has a 500 m^2 laboratory employing a team of five doctors, 18 nurses and technical staff, and five secretaries. Some 27,000 tests were carried out in 1977, the work of the department being divided between therapy (pacemaker treatment both internal and external) and testing (cardiac catheterization, body plethysmography, pulmonary diffusion tests, effort testing of patients with ischaemic heart symptoms, skin circulatory rate, and registration of pressure during various operations). The entire range of tests is listed in a table. Each day's work is planned on the basis of a staff meeting, and staff also attend all medical conferences. Patients are kept fully informed about all procedures, and are accompanied throughout their visit to the department by staff from their own ward. The article is illustrated with four interior photographs and two textbook diagrams.

ORTHOPAEDICS

912. LOWTHIAN, P. **Pressure sore prevalence: a survey of sores in orthopaedic patients.** *Nursing Times*, London, 1979, March 1, vol. 75, no. 9, pp. 358-360.

A one-day, point-prevalence survey of pressure sores carried out at the Royal National Orthopaedic Hospital, Stanmore, is reported. The survey was carried out by three of the hospital nursing officers and a research assistant who was also a nurse. Of the 186 patients, 29 (15.6 per cent) were aged 70 or over and (43 per cent) were under 30 years. Thirteen (seven per cent) of the patients had at least one pressure sore, but not all of these were open sores. Pressure sores were associated with old age and poor mobility. The majority of sores were found on patients who had spinal injuries, multiple sclerosis, tuberculosis of the spine or spina bifida. Ten of the total of 28 sores were located on the buttocks. The small number of patients found to have sores makes it difficult to draw any firm conclusions, though they are discussed briefly.

UROLOGY

913. HANSEN, L., KOLMOS, H. J. J. and SIBONI, K. **Detection of cumulations of infections in hospital over a three-year period using electronic data processing.** *Danish Medical Bulletin*, København, 1978, Dec., vol. 25, no. 6, pp. 253-257.

The results of bacteriological examinations of 3,475 specimens from a nephrological ward and 2,836 specimens from a urological ward at Odense University Hospital were recorded by electronic data processing over a three-year period. The number of patients with the same species in a category of specimen was compared with the number in the two previous six-month periods. Although four different accumulations of infections had already been detected, two previously unnoticed accumulations with *Klebsiella pneumoniae* and *Staphylococcus aureus* were discovered. The system made possible a comparison of the distribution of one or more species in several categories of specimens at various times within one ward or at the same time in different wards. Although the system could predict the probability level of infections occurring, it could not identify the causes.

914. SCOTTISH LOCAL AUTHORITIES SPECIAL HOUSING GROUP. **Home dialysis.** 2nd edition. Edinburgh, Scottish Local Authorities Special Housing Group, 1978, [i], 19pp. £2.00

This second edition presents current information on the latest advances in techniques and equipment for home dialysis. Aspects covered include: overall needs and responsibility; type of accommodation; outline of treatment; and general requirements.

915. TRAFFORD, J. A. P. and others. **Evaluation of ultra-short dialysis.** *British Medical Journal*, London, 1979, Feb. 24, vol. i, pp. 518-519.

A study was carried out to compare the effects of three dialysis regimens of different durations: (i) 19 patients were dialyzed for only 11.2 hours per week (1975-7); (ii) nine patients were dialyzed for 24 hours per week (1974-6); and (iii) 10 patients were dialyzed for 27 hours per week (1971-3). Clinical, biochemical and haematological results showed that the short dialysis regimen was as effective as the longer regimens, except that patients had to take a phosphate binder regularly, and that it was considerably cheaper. Short dialysis has social and economic benefits, since patients have more free time and more patients can be treated with the same number of staff and dialysis stations. As in many areas there is a shortage of places for patients needing dialysis, a short regimen is recommended.

916. TOLKOFF-RUBIN, N. E. and others. **Cytomegalovirus infection in dialysis patients and personnel.** *Annals of Internal Medicine*, Philadelphia, 1978, Nov., vol. 89, no. 5, part 1, pp. 625-628.

A 12-month study of cytomegalovirus infection was undertaken at the Massachusetts General Hospital Hemodialysis Unit. Ten out of 80 patients developed active cytomegalovirus infection. Seven infections coincided with renal allograft rejection and three patients developed the infection three to six weeks after massive transfusions of conventional blood. There was no contact between these groups of patients. Twenty-one patients who received frozen blood after dialysis did not develop cytomegalovirus serologies; neither did 26 members of staff, all of whom had been in direct contact with the patients. Transmission of cytomegalovirus infection with transfusion of conventional blood is probably caused by a virus carried by leukocytes. Frozen blood, however, is free of active leukocytes and its use significantly reduces the risk of cytomegalovirus infection following transfusion.

917. LINNEMANN, C. C., MCKEE, E. and LAVER, M. C. **Staphylococcal infections in a hemodialysis unit.** *American Journal of the Medical Sciences*, Thorofare, N.J., 1978, July/Aug., vol. 276, no. 1, pp. 67-75.

Epidemics of infection with *staphylococcus aureus* in the haemodialysis unit of the Cincinnati General Hospital increased during the years 1975 and 1976. In 1975 there were 12 staphylococcal infections involving eight patients, but in 1976 the infection rate increased significantly following the increase in size of the unit and the admission of a number of diabetics for long term dialysis. Most infections involved the site of the fistula and were associated with bacteremia; four were shunt infections. Patients responded to treatment with antibiotics and, in all but two cases, fistulas were not removed, but shunts were. By May 1976, 16 of 50 patients and 10 of 36 staff were positive for *staphylococcus aureus* involving multiple phage types. The epidemic

decreased after the introduction of infection control measures, including the use of sterile dialysis trays. The management of infected patients by antibiotic therapy is described.

918. MADER, J. T. and REINARZ, J. A. **Peritonitis during peritoneal dialysis—the role of the preheating water bath.** *Journal of Chronic Diseases*, Oxford, 1978, vol. 31, nos. 9/10, pp. 635-641.

Peritoneal dialysis has several potential complications including peritoneal infection. Of 116 patients undergoing peritoneal dialysis for renal failure at the University of Texas Medical Branch Hospitals, Galveston, Texas, clinical peritonitis with positive bacterial cultures was revealed in 25 per cent and positive peritoneal cultures in 45 per cent. An epidemiological investigation strongly suggested a causal relationship with water baths used to preheat the dialysis solutions. To reduce exogenous contamination during preheating, the water baths were filled with 0.25 per cent acetic acid which was changed every eight hours. Analysis of the 50 subsequent admissions indicated that clinical peritonitis was reduced to 10 per cent and positive cultures to 28 per cent. This clinically important hospital infection may be prevented to a significant extent by aseptic care of dialysis bottles and tubing and by use of bacteriostatic solutions in the preheating water bath.

919. MORTON, J. B. and LEONARD, D. R. A. **Cadaver nephrectomy: an operation on the donor's family.** *British Medical Journal*, London, 1979, Jan. 27, vol. i, pp. 239-241.

Thirty-two relatives of cadaver kidney donors in Christchurch, New Zealand, were interviewed about six months after the donor's death. Most had a positive attitude to kidney transplantation and this was strengthened by the experience of being related to a donor, especially when they knew that the donor's wish was being fulfilled. All but two relatives were surprised when the subject of permission for donation was raised, but 25 families remembered the interviewers as kind. Twelve did not understand the doctor's poor prognosis and seven reacted adversely to the interviewers, finding them blunt and callous. However, only two had refused permission and many had found some comfort in knowing that the death had helped others. Doctors caring for dying patients should give relatives full information on the patient's condition and permission for organ recovery should not be sought until they understand that death is inevitable.

SURGERY

See Abstract Nos. 845, 899

MATERNITY

See also Abstract Nos. 849, 922

920. BLACK, D. P. and GICK, S. **Management of obstetric complications at a small rural hospital.** *Canadian Medical Association Journal*, 1979, Jan. 6, vol. 120, no. 1, pp. 31-34, 37.

A review of the experience of the 40-bed Baie Verte (Nfld.) Peninsula Health Centre

found that there is no satisfactory method presently available that enables a hospital to identify maternity patients in whom complications will develop. While the scoring system designed by Goodwin, Dunne and Thomas for assessing antepartum fetal risk is fairly effective in selecting foetuses at risk, its results do not correlate well with the frequency of obstetric complications. Since in a significant proportion of obstetric patients, complications develop that require emergency intervention, it is important that hospital staff maintain their ability to carry out safe caesarean sections and to obtain blood for transfusion quickly. Hospitals in which there are fewer than 100 deliveries per year probably do not have a sufficient case load to maintain the ability to do safe caesarean sections; it is therefore suggested that they discontinue obstetric practice. At hospitals with a larger case load elective caesarean sections should be done so that the ability to do emergency procedures can be maintained.

DENTISTRY

921. Department of Health and Social Security, Scottish Home and Health Department and the Welsh Office, Expert Group on Hepatitis in Dentistry. **Report to the Chief Medical Officers and Chief Dental Officers of the Department of Health and Social Security, the Scottish Home and Health Department and the Welsh Office.** (Chairman: Professor Sir Robert Williams). London, Her Majesty's Stationery Office, 1979, [ii], 4pp. £0.20

A small but unknown proportion of healthy individuals have a positive reaction to hepatitis B surface antigen (HBs Ag). Tests of infectivity have not yet been developed and the degree of risk is not known. Recommendations are put forward to deal with the situation including: (i) the wearing of suitable gloves by surgeons and staff; (ii) thorough sterilization; (iii) the use, where possible of disposable equipment; (iv) the use of a fresh cartridge of local analgesic and disposable needles; (v) the wearing of spectacles and a facemask; (vi) the disinfection of all working surfaces; (vii) the use of conventional low-speed handpieces and traditional methods of scaling; and (viii) known carriers should be treated at the end of a session. Special categories of high-risk patients should be treated in suitably equipped hospital dental departments. Dentists and their staff known to be antigen positive but with no clinical symptoms may continue to work but take stringent precautions. An appendix gives advice on sterilization and disinfection.

922. Nixon, G. S. and others. **Pregnancy outcome in female dentists.** *British Dental Journal*, London, 1979, Jan. 16, vol. 146, no. 2, pp. 39-42.

Several occupational hazards of dentistry have been identified. This paper describes a pilot study initiated by the British Dental Association to examine the obstetric history of female dentists. From 2,800 female dentists to whom a questionnaire was sent, 1,615 usable replies were received; of these, 1,271 were married and 932 reported a total of 2,291 pregnancies. Clinical dental practice was associated with an increased frequency of spontaneous abortion, especially late abortion. However, this occupational exposure did not appear to influence the frequency of congenital abnormalities, stillbirths or involuntary infertility. The perinatal mortality rate was somewhat higher than may be expected for a social class I group.

PSYCHIATRY

See also Abstract Nos. 862, 864, 890, 892, 903

923. CHISWICK, D. **Operating the Mental Health Acts.** *British Journal of Hospital Medicine*, London, 1979, Feb., vol. 21, no. 2, pp. 167-170, 172, 174-175.

This paper describes current legislation in the United Kingdom for the compulsory admission of psychiatric patients, and gives some practical guidance on the manner of implementing the various procedures in different situations. A brief summary of the major proposals contained in the recent government white paper on the Mental Health Act, 1959, is also included.

924. QUINN, S. **Management of an interim secure unit: coping with the problems of running Lyndhurst Unit, Hampshire.** *Nursing Times*, London, 1979, Feb. 8, vol. 75, no. 6, pp. 237-240.

Lyndhurst Unit in Knowle Hospital, Fareham, is an interim secure unit, run as an open unit with a high staff-patient ratio. Five brief case histories are given to illustrate patient problems. The unit's team consists of one consultant, two registrars, 30 nurses, one social worker and a part-time psychologist, nursing officer and occupational therapist. A patient referral from a general practitioner is assessed for suitability for admission by members of the unit team. Treatment includes a high degree of personal attention, involvement in work projects, out-patient follow-up and drug therapy where appropriate. Seclusion in the secure room is used as a preventive and not as a punitive measure. The aim is to return patients to their catchment psychiatric hospitals, or to their homes, but this is not always possible and a shortage of community housing makes rehabilitation more difficult. The unit has so far been successful in dealing with the clinical tasks expected of it.

925. BRACHER, L. Modificeret gruppepleje på et psykiatrisk afsnit—1. af to dele: teorien bag den plejeform vi har fundet frem til. [**A modified form of group nursing in a psychiatric unit. Part 1: the theory behind the form of nursing we have adopted so far (since mid-October 1977).**] *Sygeplejersken*, København, 1978, Nov. 15, no. 45, pp. 4-7, 20.

A high level of activity, interaction and emotional response is achieved by group nursing, which permits careful planning and organization of work, effective communications, an advisory form of leadership, encouraging and constructive co-operation, evaluation of nursing and efficiency of communication. Introduction of group nursing relocates the responsibility for decision-making at a lower level in the hospital hierarchy, as a result of which the staff must concentrate on information and responsibility rather than on authoritarianism. The core of group work is the group conference, at which plans are discussed and agreed on the basis of written nursing instructions. The psychiatric ward at Nordvang County Hospital was opened in mid-October 1977 on the group care principle. All seven categories of staff received the sister's introductory material a month in advance, and spent a fortnight planning details of operation. The second half of the article (*Sygeplejersken* no. 46) describes experience to date, and includes a bibliography. The article is illustrated with six internal photographs.

926. HIRSCH, S. R. and others. **Shortening hospital stay for psychiatric care: effect on patients and their families.** *British Medical Journal*, London, 1979, Feb. 17, vol. i, pp. 442-446.

One year's admission of patients with acute functional disorders to a psychiatric unit were allocated at random to short stay care (the experimental group), or to standard care (the control group). Altogether 127 patients were interviewed on admission and 106 were followed up. After 45 days, a greater proportion of the short stay group had been discharged, but after this time, the short stay policy made no difference to length of stay. Rates of improvement during the three months following admission were essentially the same for both groups, including those produced by the Patients' Behaviour Assessment Scale, a method used to measure distress and other adverse effects on the patient's family. There was no difference between the two groups in demands made upon the social services, social security requirements or general practitioner visits. Short stay care resulted in a 33 per cent reduction in average length of stay but was associated with a corresponding increase in day hospital use. Shortening the hospital stay is, therefore, beneficial to both the patient and his family, provided day care help is adequate.

927. DEPP, F. C. **Increased legal intervention and psychiatric hospitalization changes.** *Ethics in Science and Medicine*, Oxford, 1978, vol. 5, nos. 2-4, pp. 89-98.

Since the passing of an act in the District of Columbia in 1964, legal monitoring and interventions have increased for emergency psychiatric patients at St. Elizabeth's Hospital, Washington, in line with a national trend. Two groups of patients admitted as emergencies in 1969 and 1972 respectively were studied. Between these dates the number of legal commitments to long hospital stays decreased, patients were released earlier, were re-admitted more frequently and attended longer as out-patients. The data suggest that discharge may have been given prematurely to the 1972 group as legal monitoring made patient constraint harder to achieve. However, there is no evidence that early release proved a danger for either the patient or the community. There seems little doubt that legal intervention has altered the course of treatment for emergency admissions. The effect of this alteration has been, on the one hand, early release and frequent re-admission and, on the other, the prevention of extended in-patient stays.

928. STUMPFE, K. D. and HUSSER, J. Untersuchung über Zwangseinweisungen von psychisch Kranken. **[A study of compulsory admissions to psychiatric hospitals.]** *Öffentliche Gesundheitswesen (Das)*, Stuttgart, 1978, Dec., vol. 40, no. 12, pp. 808-814.

This is a study of 541 compulsory admissions to psychiatric hospitals under West German mental health legislation from the City of Essen during 1971 and 1972. The form on which the medical report recommending admission is made is reproduced. Of the 541 patients 48.1 per cent were males and 51.9 per cent females. The age groups most concerned were 41-50 (25 per cent) and 70 plus (18.1 per cent): 19.2 per cent were single, 41.8 per cent married, 11.6 per cent divorced and 22.4 per cent widowed. The main diagnoses were: psychosis (40.5 per cent), mental disturbance (23.5 per cent), drug addiction (34.6 per cent) and mental deficiency (8.3 per cent).

929. PITCHER, D. and SERGEANT, H. **Individual patient-doctor contact in a mental hospital.** *Psychological Medicine*, Cambridge, 1978, Nov., vol. 8, no. 4, pp. 705-710.

Friern Hospital, London, serves three Greater London boroughs; this study was

confined to two divisions: Camden and Islington. Data collected from 1 May to 31 July 1972 showed that patients stayed on average for about five weeks and spent a total of less than two hours individually with senior and junior doctors. Long-stay patients (one year or more) saw their doctors for an average of less than one hour a year. These findings, in which the case of junior doctors were corroborated in a further study in 1974, refer only to the time doctors spent with patients alone. The admission, and long-stay discharge rates were greater in the Islington than in the Camden division, and probably reflect differences in clinical practice. It is argued that more psychiatrists are needed—precisely how many will depend on studies of the relative efficiency of different services and training programmes, and on agreement among psychiatrists about minimum professional standards.

930. LAMBOURN, J. and MURRILLS, A. J. **Actual practice of ECT in a health region of Britain.** *British Journal of Psychiatry*, London, 1978, Dec., vol. 133, pp. 520-523.

All of the 14 electroconvulsive therapy (ECT) centres in Britain serving a region of 2.7 million inhabitants were visited. Using an itemized check-list, their treatment statistics, operational policies and physical provisions in terms of staff, structure and equipment were recorded. The reliability and safety of electrical stimulus equipment were tested on site. The Royal College of Psychiatrists' memorandum on the use of ECT provides a useful discussion document, but lacks the detail necessary for its application as an operational policy. The recommendations regarding anaesthetic agents and electrode placement are at variance with clinical practice, which has a better theoretical basis. The memorandum rightly stresses the need for better training of the staff applying ECT but neglects to emphasize the need for maintenance of the electrical equipment, which was found to be inadequate.

931. DEPARTMENT OF EDUCATION AND SCIENCE. **The education of children in hospitals for the mentally handicapped: a survey of educational provision in sixteen hospitals for severely mentally handicapped children, carried out by Her Majesty's Inspectors and a Medical Advisor during the autumn and spring terms 1976-77.** (HMI Series: Matters for Discussion 7) London, Her Majesty's Stationery Office, 1978, 22pp. £0.65

This survey of educational provision was undertaken by a team of four inspectors of education with particular responsibility for the education of mentally handicapped children. Sixteen hospital schools were visited representing about a fifth of the total number of hospital schools for mentally handicapped children. Aspects covered in the survey include: the children; staff; accommodation; equipment; school holidays and hours; organization; education; and supporting services. The advances made in the care of the mentally handicapped child and the problems are discussed and the conclusions summarized. An appendix lists the numbers of children receiving education in hospital schools, and on wards, and those non-resident children receiving education in hospitals and elsewhere.

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